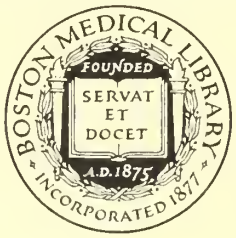
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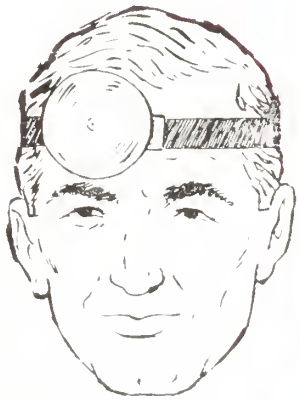
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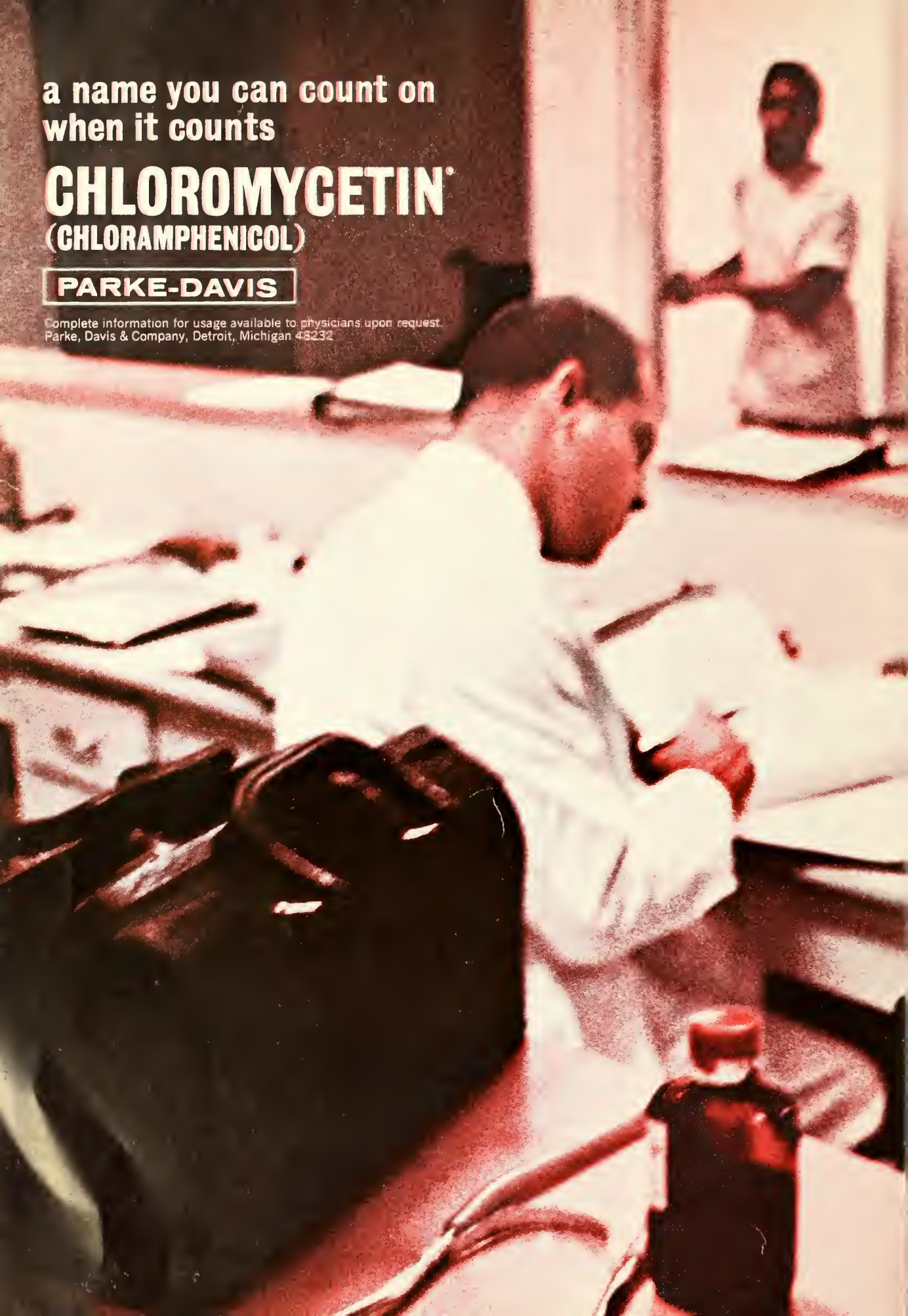




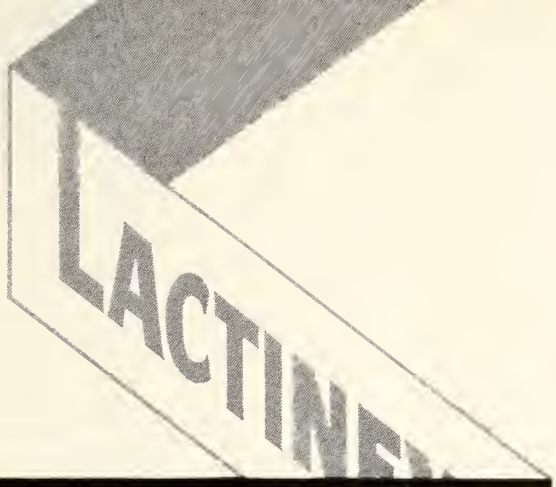
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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AMA Booklet on Drug Dependence Available for Distribution

Widespread concern, particularly among alarmed patients, over the nation's rising drug abuse problem and the raging "front-page" controversy centered around the increasing use of LSD, marijuana, and other hallucinogenic drugs by thrill, curiosity, and "self-improvement" seekers on and off college campuses has spurred the American Medical Association to develop a 25-page booklet, "The Crutch That Cripples: Drug Dependence."

The publication is designed to give the public a sound understanding of drugs, their uses and abuses and the problems which irresponsible use leaves in its wake.

The publication was prepared by the Committee on Alcoholism and Drug Dependence, Council on Mental Health, in response to heavy mail and telephone inquiries received in recent months by the AMA's Department of Mental Health.

Written lucidly and in colorful language readily understood either by parents or the younger set, "The Crutch That Cripples" discusses all aspects of drug use.

Among the topics covered are medical uses of drugs, drug dependence, drug abusers, abuse of narcotics, sedatives, stimulants and hallucinogens, where to get help for drug abusers and prevention of abuse. The booklet also calls attention to a current bibliography available from the Department of Mental Health on drug abuse and drug dependence.

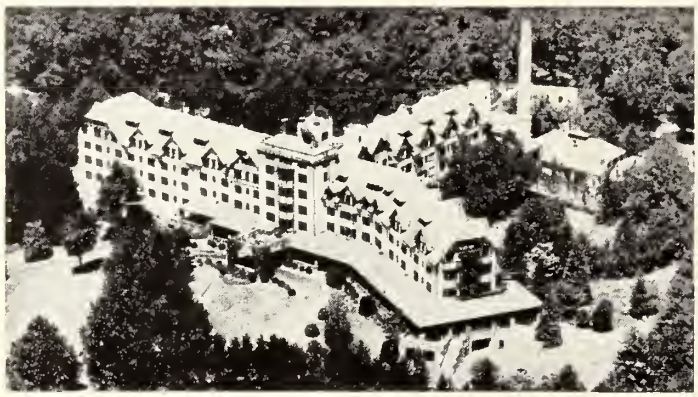
Copies of the publication may be obtained from the AMA Order Department, 535 N. Dearborn St., Chicago, Illinois 60610. Single copies are 25 cents. Reduced prices, ranging downward to 17 cents each for lots of 1,000 or more, are offered on quantity orders.

AMA Judicial Council Opinion On Physician Testimonials

In response to many requests, the AMA's Judicial Council has reiterated its opinion providing a guideline for physicians in their relations to commercial enterprises. Here is the opinion:

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this issue: the cold in pregnancy...

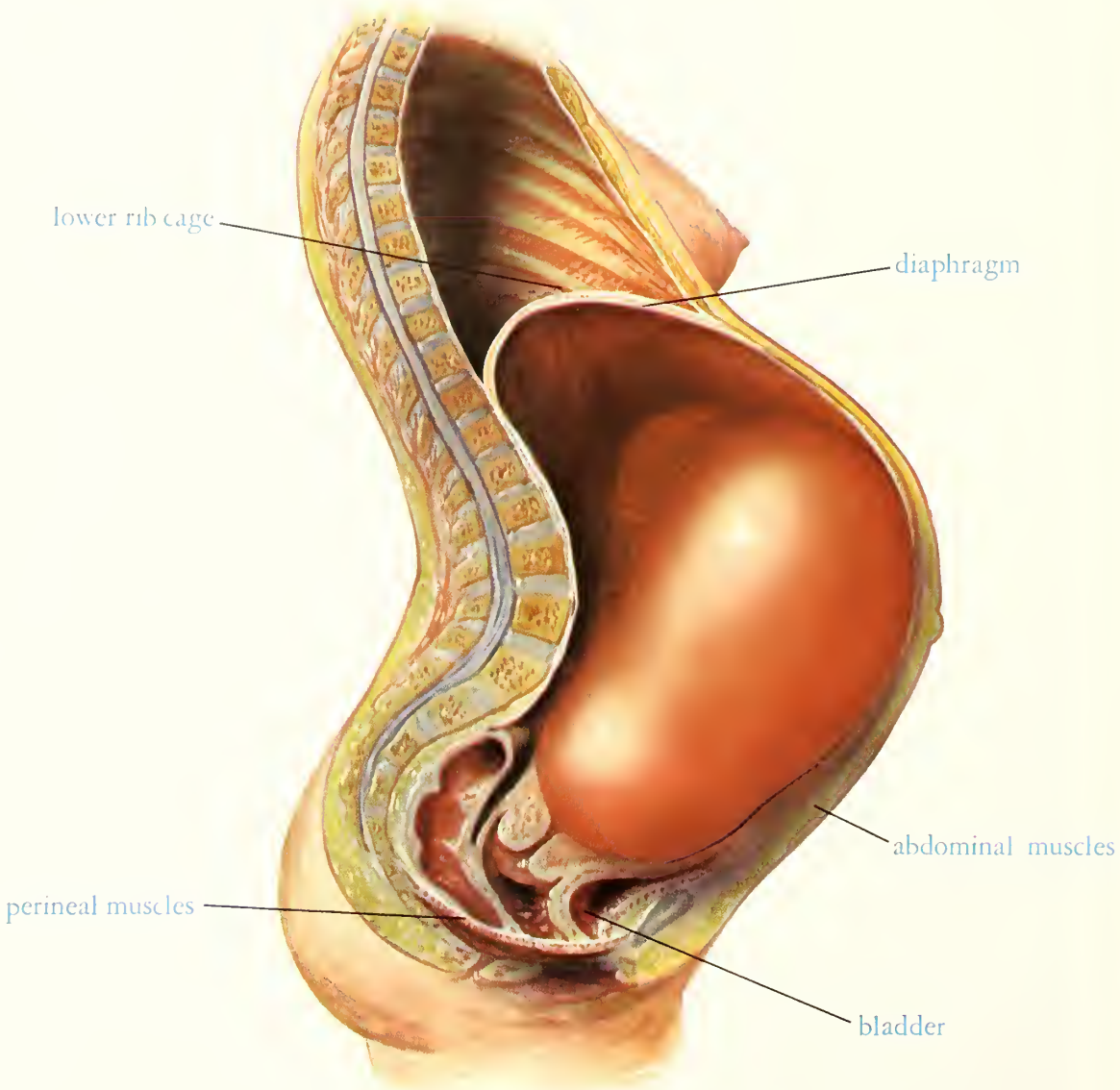
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

Less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a flaccid abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

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patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

The most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drop. The use of antibiotics in an uncomplicated cold i contraindicated and should be scrupulously avoidec

In summary, a cold in pregnancy is more severe an longer lasting. The treatment of the symptoms wit local and systemic decongestants will make th patient more comfortable.

Apparently the cold is so common in pregnancy tha it has received very little attention in the literature References are almost non-existent and the fev which are available add little to the common knowl edge, are out-dated, or are not helpful. Thus th usual bibliography is not appended.



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Extensive Environmental Health Study Centers in Cincinnati

The University of Cincinnati Medical Center, and two visiting scientists from Sweden, are playing leading roles in an extensive study of environmental health.

Throughout the United States, 8000 pairs of twins, all men, are being asked to participate in a major study of the effects of environment on human health. The research seeks information on the effect of environment, such as tobacco smoking and air pollution, on certain cardiovascular and respiratory symptoms. Questionnaires were mailed in late September.

Interested in the study are cooperating scientists at the National Academy of Sciences and University of Cincinnati Medical Center's Department of Environmental Health. The project is supported by the American Medical Association, U.S. Public Health Service National Center for Air Pollution, and University of Cincinnati.

Two noted Swedish scientists, visiting scholars at the Cincinnati University's new Center for Study of the Human Environment, composed the questionnaire. It is based on research they have done with twins in their homeland. They are Dr. Lars Friberg and Dr. Rune Cederlof, colleagues at Stockholm's Karolinska Institute and National Institute of Public Health of Sweden.

Twins in the current study are between 45 and 50 years of age. They were selected from the registry of veterans of World War II which is maintained by the National Academy of Sciences in Washington, D.C. Their existence as twin-pairs makes these 16,000 men uniquely useful in the research.

Drs. Friberg and Cederlof after returning to Sweden will make the final analysis of data.

AMDOC, Independent Agency Arranges Foreign Medical Assignments

AMDOC (AMerican DOCtor) is a person-to-person medical and educational service agency which arranges assignments of medical personnel in foreign countries. It is nonprofit, and is not religiously oriented. Its roster of hospitals in foreign areas contains numerous requests for general practitioners, physician specialists, dentists, and allied personnel. Assignments are available in Central and South America, the Far East, Southeast Asia, and Africa.

Ohioans on the Working Board — those who have completed assignments with AMDOC — are Dr. Mabel Emery, Mansfield (India), and Dr. Ignor F. Nikishin, Canton (Haiti).

Details may be obtained by writing the Executive Secretary, Dennis G. Karzag, 27 East Canon Perdido Street, Santa Barbara, California 93101.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

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OHIO OFFICES:

CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

CLEVELAND: 11955 Shaker Blvd., (216) 795-3200, A. C. Spath, Jr., R. A. Zimmerman

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter



Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (includ-

When a milestone in life is marred by depression...



Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by such symptoms of depression as feelings of sadness, incapacity, helplessness and hopelessness.

In about 3 out of 4 cases, Tofrānil relieves symptoms of primary depression.

As maintenance therapy in primary depressive illness, it helps prevent relapse.

Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

Tofrānil® imipramine hydrochloride
Geigy

g hypomanic and manic episodes) hich may require dosage reduction d/or addition of a tranquilizer or mporary discontinuation of the drug, ileptiform seizures, orthostatic potension and substantial blood essure fall in hypertensive patients, rpura, transient jaundice, bone marw depression including agranulocysis, sensitization and skin rash cluding photosensitization, eosinoilia, and mild withdrawal symptoms sudden discontinuation after prolged treatment with high doses. ccasional hormonal effects (imtence, decreased libido, and estronic effects) may be observed. ropine-like effects may be more pnounced (e.g. paralytic ileus) in sceptible patients and in those ing anticholinergic agents (includ antiparkinsonism drugs).
tpatient Adult Dosage: Initially, mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Set Your Affairs in Order...

Reminders of Data that Every Physician May Wish to Compile Now; Information that Family and Associates May Sometime Appreciate

OFTEN A PHYSICIAN'S DEATH, expected or not, creates difficult tasks for the survivors. The natural grief is complicated by the necessity for rapid decisions and hurried searches for required information. Significant papers or information may be so well put away that prolonged seeking in various places may be required, with added pain for the bereaved.

Accordingly, it is suggested that the physician during his lifetime ease the situation by compiling in one place needed information, locations of papers, records, etc.

To assist in this procedure, the Academy of Medicine of Cleveland has prepared a check list for its members so that data will be readily at hand. *The Journal* is reproducing this list with permission of the Cleveland Academy, in the hope that it will be useful to physicians throughout the state. The original check list is in pamphlet form with write-in blanks.

This check list may provide an additional purpose —that of a reminder of details that should be arranged, and information that should be compiled. The list has been compiled with the assumption that a will has been prepared, insurance has been provided for, and a trust, if desired, established.

1. Social Security Number
   Taxpayer Identifying Number
2. Accountant or Estate Planner:
   Name
   Address
   Phone Number
3. Attorney: Name
   Address
   Phone Number
4. Employee(s):
   Name
   Address
   Phone Number
   Social Security Number
   Terms of employment as regards termination of services
5. Funeral Director: Name
   Address
   Phone Number
6. Cemetery Lot: Location of Deed
7. Insurance Agent (and/or Estate Coordinator)
   Name
   Address
   Phone Number
8. Stockbroker:
   Name
   Address
   Phone Number
   Firm
9. Trust—If Established:
   Name of trustee(s)
   Address
   Phone Number
   Name of bank's representative if trustee is a bank
10. Will: Location
    Location of any codicils
11. Home: Location of deed
    Location of mortgage papers
    Other
12. Office: Location of deed or lease
    Location of mortgage papers
    Duration of lease or term of mortgage
    Provisions for settling in event of death
13. Other Real Estate:
    Location(s)
    Location of deed(s)
    Location of mortgage papers
    Other
14. Life Insurance Policies: Location and Numbers
15. Other Insurance Policies: Location and numbers
16. Physician Coverage and/or Referral (temporary):
    Dr.
    Address
    Phone Number
17. Securities: Location
    Cost figures location
18. Current Unpaid Bills: Location
19. Outstanding Obligations:
    a) Notes, Location
    b) Mortgages, Location
    c) Pledges (charitable, etc.)
    d) Charge accounts
    e) Credit checking accounts
    f) Collateral (stocks, etc.)
    g) Other
20. Safe Deposit Box(es): Number and Location
    Location of Keys

(Continued on Page 23)



Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.) ..... 16.2 mg.
(Warning: may be habit forming)
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate.....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2),
½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A·H·ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

When the agitated businessman goes to work...

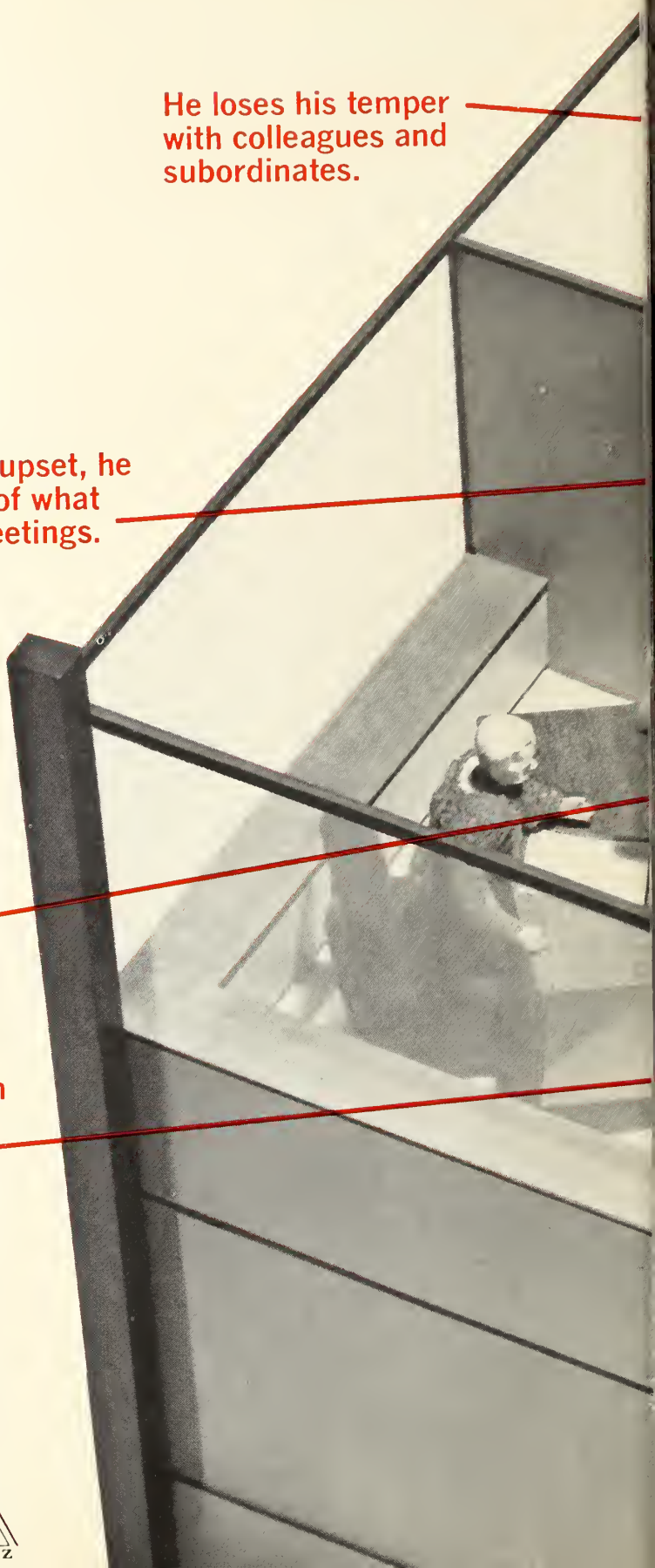
He goes home at night and takes it out on his family.

He loses his temper with colleagues and subordinates.

Emotionally upset, he misses half of what is said at meetings.

He is always fearful about his standing with the boss.

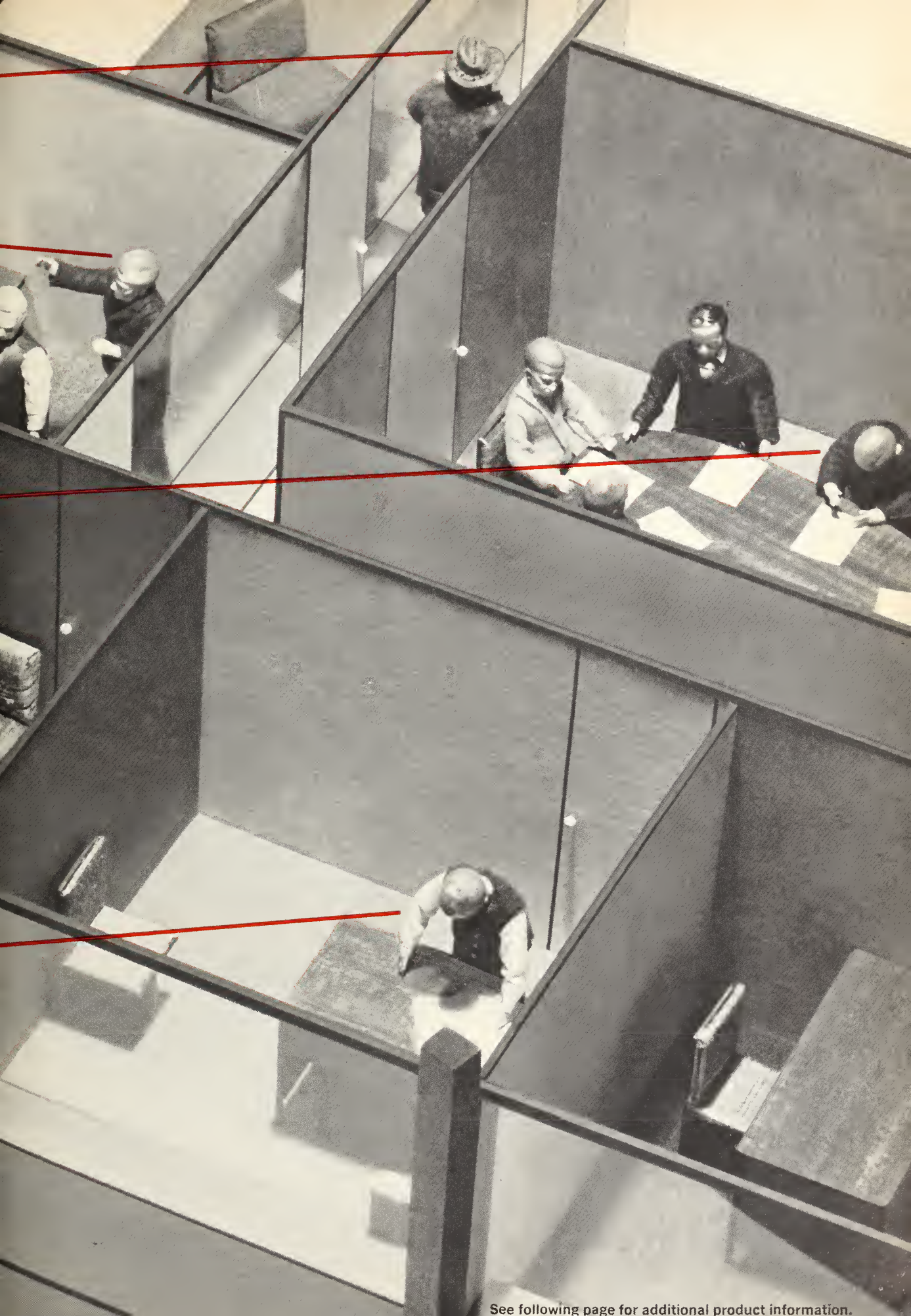
He just can't seem to settle down to his work.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ



See following page for additional product information.

When the agitated businessman goes to work...

Anxiety that seriously interferes with the individual's performance at work, at home, or in the community may be regarded as *moderate* to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Set Your Affairs in Order

(Continued from Page 18)

21. Savings Account(s):
    Numbers & Banks
    Location of pass book(s)
22. Checking Account(s): Numbers and Banks
    Location of check book(s)
23. Financial Records: Location
24. Cash: Location of records of accounts receivable
    Location of unbanked cash
    Suggestions for immediate cash if needed
25. Tax Information—Federal, State, Local:
    Location of
26. Accounts Receivable: Location
    Views on sending current bills
    Views on collection of delinquent bills
27. Notes, Loans, Mortgages, etc. Due from Others:
    Items
    Location
    Pensions and other benefits due
28. Notifying Patients: Suggested method
    Future appointments—location of book
29. Notify Hospitals
    Phone Number(s)
    b) Colleagues
    Phone Numbers
    c) Local Academy
    Phone Number
    d) Other Societies, etc.
    Phone Numbers
30. Veterans Administration—you may be eligible for unexpected benefits including burial allowance, headstone or marker, flag, death pension for widow and/or children. Consult Veterans Administration Fact Sheet IS 1, January, 1962, and any future supplement, obtainable from the Veterans Administration.
    Location of discharge papers
    It would be wise to have photo copies made
    Branch of service
    Date of discharge
    Service number
    VA number(s)
    Other
    Expected benefits
31. Blue Cross, Blue Shield, other Health Insurance:
    Location and Numbers of Policies
32. Narcotics:
    Location of drugs
    Location of tax stamp
    Location of narcotics ledger
    Location of order book
33. Equipment (major):
    Purchase price and date
    Suggested sales outlet
34. Views on Disposition of Property, Securities, Anticipated Income, etc.
35. Birth and Marriage Records: Location
36. Citizenship Papers (if applicable): Location
37. Special Instructions

Second Socio-Economics Congress Is Scheduled in Chicago

The Council on Medical Service and the Division of Socio-Economic Activities of the American Medical Association will sponsor the Second National Congress on Socio-Economics of Health Care on March 22-23, 1968 at the Palmer House in Chicago.

The Congress will bring together authorities from medicine, health care administration, social science, education, community planning, and other disciplines to report on new developments and techniques in meeting the increased demand for health services.



SUCCESSOR TO CHLORAL

NONE OF ITS DISADVANTAGES

NOW AVAILABLE
for the first time
Full 7½ gr. Tablet
BLUE COLOR

AVAILABLE THROUGH YOUR WHOLESALER

BLESSINGS, INC.
Cleveland 3, Ohio
References on request

(CHLORAL GLYCINE MIXTURE)

DRICLOR™

ALL OF ITS ADVANTAGES

insures full sedative action

• LESS TOXIC • NON-IRRITATING • STABLE

Chloral — the "old reliable" — for more than 100 years is dramatically improved in DriClor (chloral hydrate with the amino acid glycene). DriClor is less toxic . . . more stable . . . non-irritating to the stomach . . . and more effective grain for grain.

The effective sedative, hypnotic and anti-convulsant form of Chloral Hydrate.

Also Chlorasec for quick, even sleep. DriClor inner core (equivalent to 3.75 Grs. of Chloral Hydrate). Secobarbital acid outer coat (.75 Grs.)



WHAT DOES GALVANIC SKIN RESISTANCE DEMONSTRATE ABOUT THE EFFECT OF VALIUM (diazepam)?

Galvanic skin resistance... one measure of the Valium (diazepam) effect in reducing the somatic response to acute stress[1,2]

The subjective value of Valium (diazepam) has been proved by many clinical and empirical evaluations. Now, also objective criteria such as used in other areas of scientific research have demonstrated the effectiveness of Valium (diazepam) in reducing certain somatic responses to acute stress.

Devised as a research tool in psychosomatic medicine, this interesting method records respiratory excursions, galvanic skin resistance, cardiac activity and finger pulse volume as physical responses to stress. These autonomic nervous system responses to a standardized stressor—a film dealing with life-threatening incidents—are continuously monitored on the polygraph.

This gives a graphic representation of changes which the body may undergo in reacting to stress. The application of modern statistical analysis to these graphs provides a yardstick by which the calming effect of Valium (diazepam) can be measured quantitatively.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with a history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See *Precautions.*)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

Roche Laboratories, Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

References: 1. Selesnick, S. T., and Clemens, T. L.: From research film "Motion Picture Films in Psychosomatic Research," available from Roche Laboratories. 2. Clemens, T. L., and Selesnick, S. T.: *Dis. Nerv. System, 28*:98, 1967.

VALIUM® (diazepam) Roche®

useful for somatic symptoms of psychic tension



Health Insurance Benefits Increased by 5 Per Cent

Health insurance benefits paid by insurance companies amounted to $3 billion during the first half of 1967, the Health Insurance Institute reported.

This was over five per cent — $157 million — more than was received by policyholders during the first half of last year.

Should the end of the year records show that benefit payments continued at this pace, 1967 will set a record for insurance company health insurance payments received by the public in a year.

Insurance company benefits for all of 1966 totaled $5.6 billion — $4.4 billion through group policies, the remainder through individual and family contracts.

Ten years ago, in 1957, total insurance company benefits received by policyholders was $2.4 billion. The 1966 final figures represented a 170 per cent increase over the amount received a decade earlier.

As 1967 began, there were more than 158 million Americans protected by some form of health insurance, the Institute said, including 98 million covered by insurance companies.

Insurance company benefit payments are running ahead of 1966 for four of the five types of health insurance: hospital expense, medical expense, major medical expense, and disability income insurance. There was a slight decrease in surgical expense insurance.

Through June 30, hospital expense payments accounted for the single largest amount of benefits, $1.219 billion. This was up a half per cent over the $1.213 billion paid during the first six months of the previous year.

Surgical expense insurance accounted for $335 million, a two per cent drop from the $342 million paid in the first half of 1966.

Half-year benefits paid for regular medical expenses rose 3.8 per cent, from $116 million to more than $120 million.

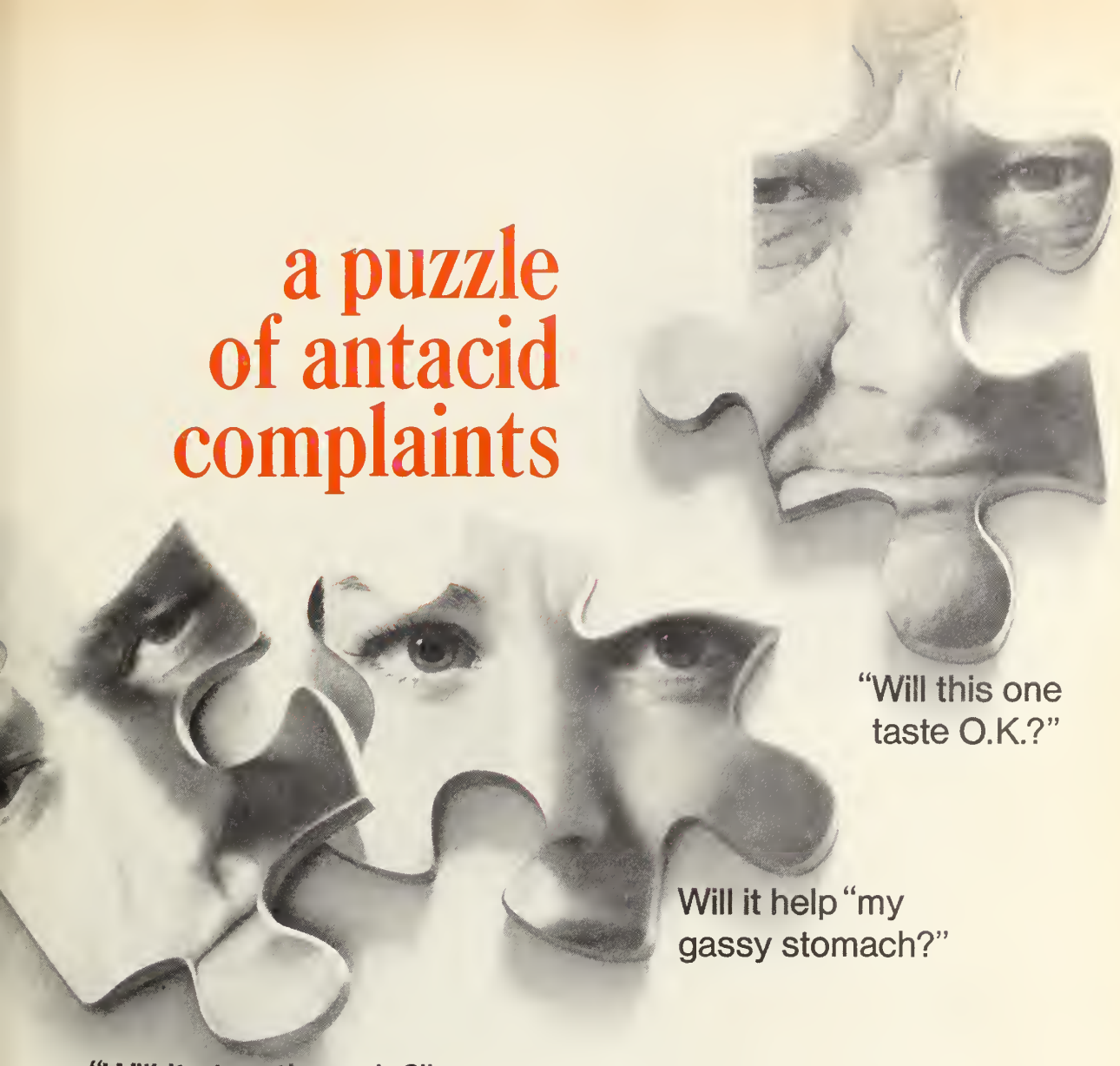
Major medical insurance, which pays benefits to offset the costs of serious illness, accounted for $736 million in benefits, an increase of 13.7 per cent over the $647 million paid during the comparable period last year.

Loss of income payments, excluding accidental death and dismemberment benefits, amounted to $603 million, a rise of 7.8 per cent over the previous year's six month figure of $560 million.

Dental expense benefits for the first six months of this year were $22 million, according to the Institute.

LSD has been scheduled for use in experiments at the Veterans Administration Hospital in Los Angeles to determine if the drug is helpful in relieving dying patients from dread and pain.

a puzzle of antacid complaints



Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

new evidence for TAO® (triacetyl-oleandomycin)

a macrolide antibiotic for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81.
(8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)
was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

ROERIG Rx
J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

For your impatient cold patients

Two sprays from NTZ Nasal Spray—and nasal congestion, rhinorrhea, sneezing are reduced for *immediate* comfort for patients with colds.

NTZ is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction on contact.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

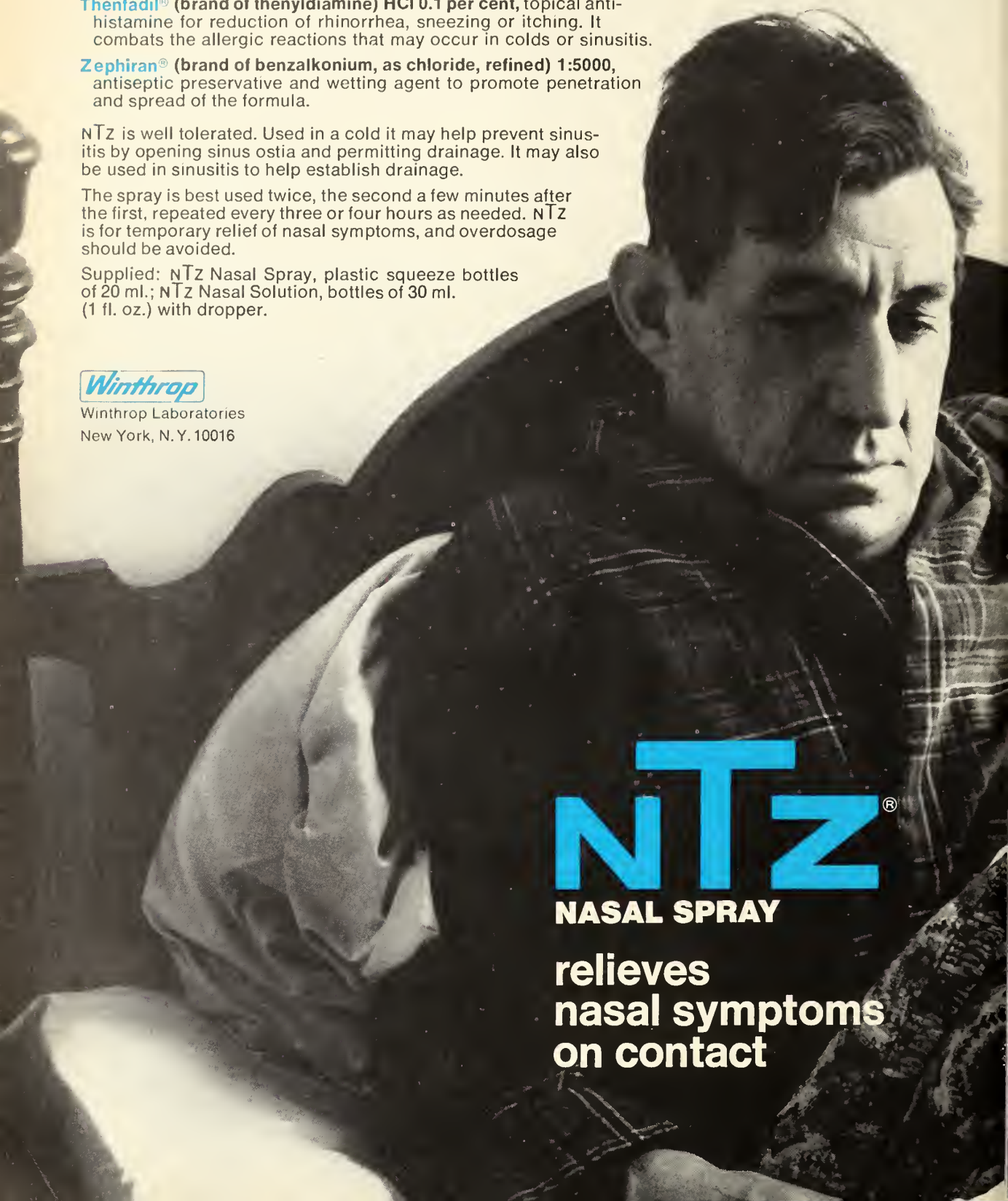
NTZ is well tolerated. Used in a cold it may help prevent sinusitis by opening sinus ostia and permitting drainage. It may also be used in sinusitis to help establish drainage.

The spray is best used twice, the second a few minutes after the first, repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms, and overdosage should be avoided.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

Winthrop

Winthrop Laboratories
New York, N.Y. 10016



New Text on Physician's Career Now Available from the AMA

The American Medical Association has developed a new publication, *The Physician's Career,* a 99-page handbook intended to serve as a teaching outline on medical practice and community relations for physicians and medical students.

More than two years in the making, *The Physician's Career* was the direct result of suggestions made at recent meetings of the AMA House of Delegates that teaching outlines of informative material on medical ethics, medical civics, and socio-economic aspects of medical practice be provided to medical schools and medical societies for orienting students and recent graduates to nonscientific aspects of the physician's career.

The handbook focuses upon the sharp transition which has occurred since two generations ago when the unaided physician was almost the only health resource in the community.

It calls attention to the fact that the short-term general hospital, once a place of last refuge for the terminally ill, has emerged into a highly organized, complex institution serving as a center of medical practice and providing the supporting services demanded by modern medical care.

A major change, it points out, is the rapid evolution of group practice. Since 1948, when 3,493 physicians practiced in 368 groups, the number in group practice had more than septupled to approximately 26,000 by 1965 and is continuing to accelerate, according to preliminary information gathered in a detailed survey now being conducted by the AMA.

The AMA is encouraging state and county medical societies to utilize *The Physician's Career* as a springboard of ideas for orientation seminars for newly installed members. Copies are being provided free to members of this year's senior medical school classes. Review copies are being sent to all state and county medical societies and medical schools.

For others, single copies are available at 75 cents each from the AMA Order Department (90 cents to those in all countries except the U.S., its possessions, Canada, and Mexico). A reduced price of 45 cents a copy has been set for medical students, interns, and residents.

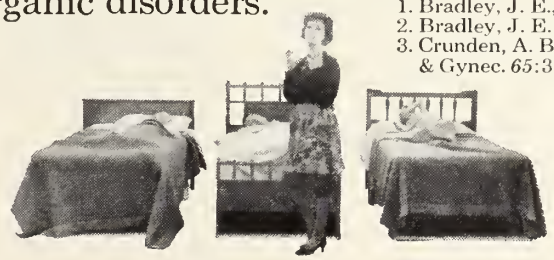
During the first year of the 1966 Veterans Readjustment Benefits Act, fiscal year 1967, 469,000 post-Korean Conflict veterans and servicemen received educational assistance at an overall cost of $251.6 million. The Veterans Administration estimates that 604,600 will take advantage of the program during 1968 at a total cost of $520.3 million.



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

in moderate hypertension and
poorly controlled mild hypertension
(when diuretics or sedatives are inadequate, for example)



When your patients expect a lot...

like relief from hypertensive symptoms
(headache, fatigue, nervousness, palpitation or insomnia, for example)

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(a schedule not unlike timed-release medication, for example)

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(at 10¢ a tablet, for example)

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...give them a little
(one tablet daily)

Regroton®

chlorthalidone 50 mg., reserpine 0.25 mg.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
For details, see complete Prescribing Information.

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Geigy

Latest Volume in the Army Series Deals With Neuropsychiatry

Neuropsychiatry in World War II, Volume I, has been published by the Historical Unit, U. S. Army Medical Service. The 826-page volume is available for purchase at $7.50 from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402.

Robert S. Anderson, Colonel, M. C., Editor-in-Chief, comments on the background of the volume as follows:

Modern war produces two unique types of casualties in large numbers: (1) physical injuries and (2) psychiatric disorders, both caused by traumatic forces catapulted from a changing and hostile environment. Battle experiences clearly demonstrate that combat psychiatric breakdown can originate from normal or previously stable personnel, as well as from those of greater vulnerability. During World War II, the Army Medical Department was confronted with the difficult task of dealing with an unprecedented incidence of psychiatric casualties for which there had been little preparation. The struggle to overcome these handicaps and the eventual establishment of effective programs of prevention and treatment present an epic achievement in military medicine.

New Film Encourages Young People To Seek Medical Allied Fields

A new film depicting the wide range of rewarding career opportunities existing in fields allied to medicine, long sought by auxiliaries and others concerned with health careers programming, is now available for bookings.

The 28-minute color film, entitled "Horizons Unlimited," after the AMA's health careers handbook of the same name, gives brief on-the-job glimpses of men and women serving in career pursuits highlighted in the publication. To give viewers greater insight as to the length of preparation and particular scope of specific professions and occupations, "thought voices" are utilized in some segments of the film.

The new film was developed solely by the AMA. Physicians, medical societies, and other medical groups should place their orders for showings, stating preferred and alternate dates, with the Films Section, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610.

A U. S. Public Health Service card called "Safety Tips In-Out-and-Around the Water," may be obtained free in quantities of up to 100 by writing to the Injury Control Program, National Center for Urban and Industrial Health, 222 East Central Parkway, Cincinnati, Ohio 45202.

In Obesity,
anorectic action
with fewer unwanted
side effects



CYDRIL®
(levamfetamine succinate TUTAG)



Cydril at 2 p.m.
Appetite control at 6
Sleep at 10

Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

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Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

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"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





when he just can't sleep

Tuinal

One-Half Sodium Amobarbital and
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supplied in ¾, 1½, and 3-grain Pulvules



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
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Medical Education Network . . .

Now in Its Sixth Year, Program Originating at Ohio State University Is Broadcast Five Times Weekly to Physicians

THOSE CONCERNED with health problems are faced today with a growing challenge, namely, getting the findings and applications of medical research from teaching centers to the practicing physician and his patient. Here is a communication problem of the first magnitude. Journal articles and research reports lag behind the actual findings by as much as six months. The doctor frequently cannot leave patients to continue his education at a teaching center. Family physicians are swamped with reading material; some helpful, some useless, but much of it cannot be read due to lack of time. Time is a precious commodity for the patient as well as his physician.

To help meet this problem, the Center for Continuing Medical Education at the Ohio State University created the Ohio Medical Education Network which today is made up of over a dozen FM radio stations and 61 hospitals in Ohio, Pennsylvania, Kentucky, and West Virginia. Five times each week at 12 noon programs are broadcast which are "live" two-way discussions between home-community physicians and medical school teachers on subjects vital to continuing medical education.

Honored Last Year

The current academic year (1967-1968) will raise the six-year attendance total to over 60,000, will bring to 76 the number of hospital staffs who have participated, and will see the 475th such program produced and broadcast. A highlight of OMEN's fifth anniversary year came with being named recipient of the 1966 Creativity Award by the National University Extension Association's Division of Conferences and Institutes.

Over 100 hour-length programs are being broadcast this year concluding in April. Teaching physicians from five different medical schools in Ohio, New York, and North Carolina will be heard talking with community physicians on such problems as Immunization Programs, Acne Vulgaris, Coronary Disease, The Emergency Room, Aging, Pediatric Hypertension, Antibiotics, Inhalation Therapy, Head Injuries, Alcoholism, Renal and Liver Disease, and Cancer. The immediacy of these programs plus the fact they can be heard by the general public help overcome the communication lag. Moreover, the program materials—slides, outlines, reprints, and magnetic tapes—all reinforce and extend the utilization of the programs into medical libraries and hospital teaching clinics. Following broadcasts, the programs and slides are also made available on tapes in the OSU Autodidactic Laboratory in the College of Medicine for reference use by medical students and practicing physicians.

Conceived in late 1961, the Ohio Medical Education Network came into existence in October 1962 with two FM radio stations broadcasting the two-way programs and involving 12 hospitals in Central Ohio. In five years, OMEN programs have resulted in some 51,000 registered attendances in network hospitals and an additional 12,000 to 15,000 are expected this year. Uncounted are the many physicians and the general public who listen in offices, homes, or automobiles.

WOSU-FM, radio outlet of OSU's Telecommunications Center is key station for the network, originating all programs and providing quality control in engineering and production.

Authorized for continuation study credit by the American Academy of General Practice, the network is supported in part by grants from the Merck Sharp and Dohme Postgraduate Program and the American Cancer Society. Across the country, the two-way technique is now being utilized by at least eight other medical institutions and serves participating physicians in eighteen states. This is postgraduate training in the doctor's own hospital at the minimum of inconvenience and time lost from patient care.

TV and Nursing

Activities of the Ohio Medical Education Network have been broadened to include nursing and television. Successful experimentation in the Spring of 1966 applied the two-way audio technique to continuing nursing education. Using 12 OMEN hospitals and two FM radio stations, four pilot programs were developed by the School of Nursing and originated from WOSU-FM on campus with signed

(Continued on Page 41)

This article was prepared for *The Journal* by William G. Pace, M. D., Assistant Dean of Ohio State University College of Medicine and Director of the Center for Continuing Medical Education, and by Robert B. Schweikart, Ph. D., Director of Communications at the Center.


or your protection . . .
injections in this office are given with TUBEX*, using
a new, sterile disposable unit with a new, supersharp,
stainless steel, siliconized sterile needle
. . . designed for one use only.
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Your name
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can mean so much
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TUBEX injectables are ready for immediate use. No measuring of doses; no filling of syringes. Saves professional time. Easy to store in the office, easy to carry on house calls.

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TUBEX injectables are premeasured, accurately and clearly identified as to name, dose, control number and expiration date (if any). Used once, then discarded, TUBEX prefilled sterile cartridge-needle units cannot cause cross contamination.

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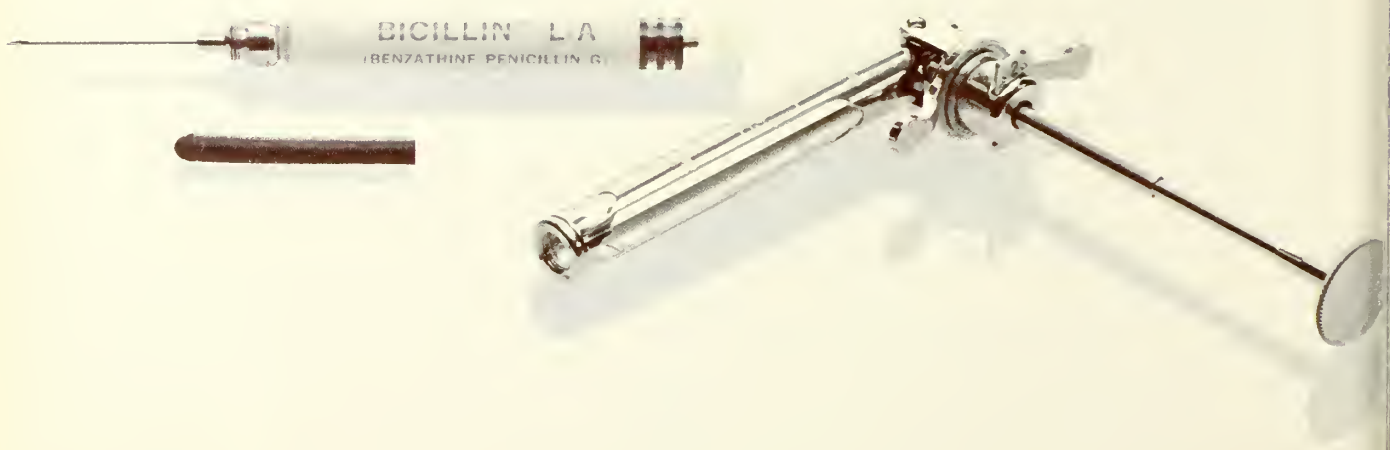
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UD UNIT-DOSE



attendance of over 2,000. This nursing network grew to 10 programs, 24 hospitals, and three radio stations in January 1967. Registered attendance exceeded 5,000. October of 1967 saw expansion to 28 programs, 48 hospitals, and 11 radio stations.

Moreover, four hour-length programs characterized as "TV with two-way audio" have also been developed and carried on open-circuit television. Produced and broadcast by WOSU-TV and simultaneously broadcast by WGSF-TV (Newark, Ohio) and several Cable TV Services, the programs linked physicians in nearly a dozen OMEN hospitals scattered throughout Ohio with College of Medicine faculty for programs on Management of Stroke Patients, the Neurological Examination, Congenital Hip Dislocation, and a Clinical Pathological Conference. Following a presentation portion, moderators in each hospital asked questions, using two-way audio techniques and equipment, of members of the program panel who were visible on TV sets. Plans are currently being prepared for further use of the "TV with two-way audio" technique in continuing medical education.

For further information, write or telephone: The Center for Continuing Medical Education, A-352 Starling-Loving Hall, 320 West 10th Avenue, Columbus, Ohio 43210; Phone: (614) 293-4985.

Five Ph. D. Candidates at Ohio State Seek Medical Teaching Careers

The Ohio State University College of Medicine has awarded the final two of five fellowships for Ph.D. candidates desiring to specialize in medical education.

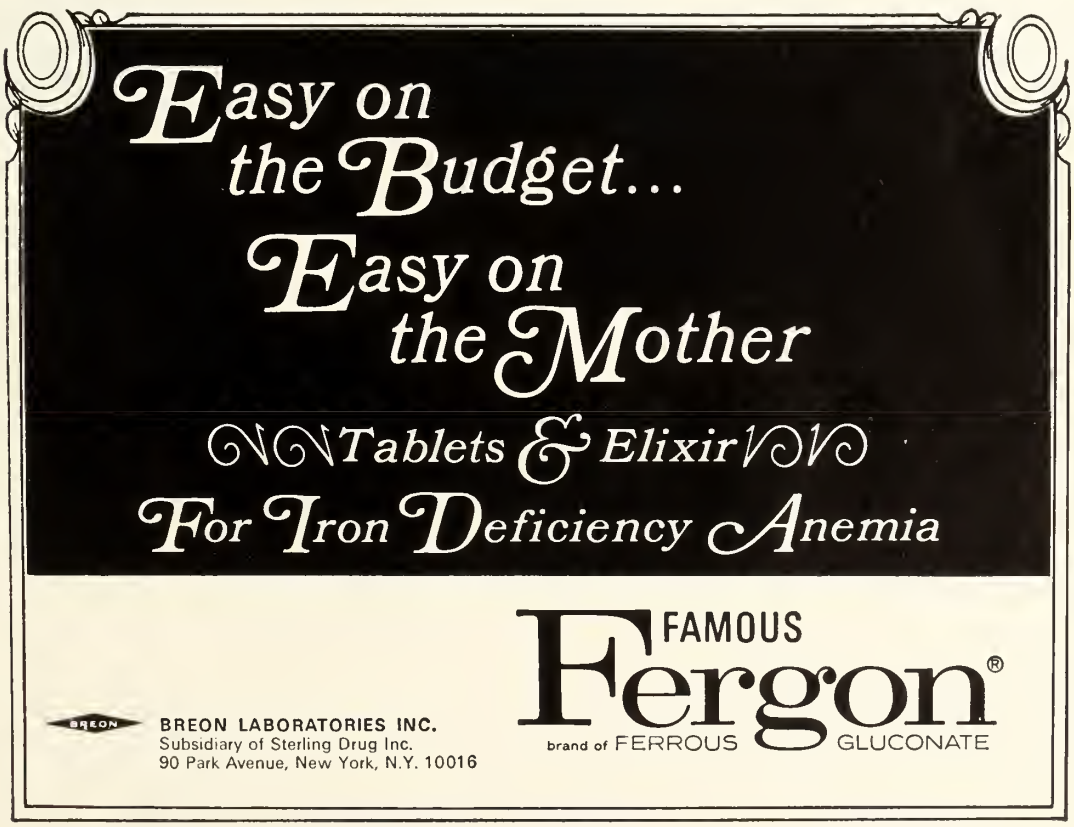
Richard Gallagher and Robert Ringe, both of Columbus, are the recipients of the $6,000 a year fellowships. Similar awards previously went to Mrs. Glenna G. Margaris, Dublin; and to Gerald A. Killeen, and Mrs. Marian Hoffman, both from Columbus.

The new program is designed for students who will receive their doctoral degrees in the field of education but will be prepared to assume teaching positions in medical schools or schools of allied health services, such as nursing.

A $76,580 grant from the National Institutes of Health, announced last September, supports the program.

The project, an interdisciplinary venture between the College of Medicine and the College of Education at Ohio State, was designed with the help of the NIH Regional Medical Program.

The five candidates will apply the techniques of education research to problems in medical education as they work on their doctoral dissertations.





treat one . . . six people benefit

The brunt of senility falls on the family as much as the patient. But usually within one or two days, 'Thorazine' can control senile anxiety and fear . . . dispel the confusion shown by nighttime wandering and chattering . . . restore appetite and interest in personal grooming. Treat the senile patient with 'Thorazine'—the whole family can benefit.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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SK&F

in senile agitation . . . Thorazine® brand of chlorpromazine



help tip the scales for your "should-but-can't" dieters...

- ☐ controls the appetite
- ☐ provides gentle 'lift' to strengthen patients' determination to stick to dietary instructions
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- ☐ special timed-release mechanism ensures smooth, uniform, 10-12 hour therapeutic effect
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- ☐ the preferred HCl salt for more available amphetamine

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TIMED CAPSULES

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Each AMODEX TIMED CAPSULE contains:

dextro-amphetamine HCl	15 mg.
amobarbital (barbituric acid derivative)	60 mg.

WARNING: may be habit forming

DOSAGE: One capsule on arising or at breakfast. Drugs are released gradually over 6 to 8 hours, providing therapeutic effect for 10 to 12 hours.

INDICATIONS: AMODEX Timed Capsules elevate the mood, relieve nervous tension, restore emotional stability and emotional capacity for physical and mental effort. AMODEX Timed Capsules are extremely useful in the treatment of anxiety states and may be used to control appetite in the management of the obese patient — without nervous excitation.

SIDE EFFECTS AND PRECAUTIONS: Frequent or continued use may cause nervousness, sleeplessness, or restlessness. Individuals suffering from high blood pressure, heart disease, diabetes, thyroid disease, lung ailments, or kidney disorders should not take this product. It should not be taken over a long period of time.

CONTRAINDICATIONS: Hyperexcitability, agitated pre-psychotic states. Sensitivity to Amphetamines or Barbiturates.

CAUTION: Federal Law prohibits dispensing without prescription.

SUPPLIED: In bottles of 30, 100, and 1000 capsules.

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Do You Know? . . . .

Dr. Middleton H. Lambright, Jr., Cleveland, a past president of the Academy of Medicine of Cleveland, was given the Distinguished Service Award of the United Appeal at a recent luncheon meeting in Cleveland.

* * *

Dr. Alan R. Moritz, provost of Case Western Reserve University, and former director of the Institute of Pathology in Cleveland, was elected president of the American Board of Pathology at a recent meeting in Cleveland. He takes office January 1.

* * *

Henry G. Cramblett, M. D., chairman of the Department of Medical Microbiology at Ohio State University, has been named to the National Institutes of Health's Clinical Research Fellowships Review Committee for a term ending June 30, 1970.

* * *

Dr. William D. Holden, director of the Department of Surgery, Case Western Reserve University School of Medicine, was elected in September as chairman of the American Board of Surgery.

Dr. Howard P. Taylor, Cleveland, has been named to the medical advisory board of *Expecting*, a publication of the Parents' Magazine Enterprises, Inc.

* * *

The Garrettsville Chamber of Commerce honored two local physicians at a dinner meeting for their service to the community — Dr. Myron Thomas and Dr. H. B. Elwell. Dr. Thomas retired from practice in 1963 and Dr. Elwell has accepted a position in industrial medicine at the Aerojet General Corporation at Marshall Space Flight Center, and will make his home in Huntsville, Alabama.

* * *

Dr. Barnet R. Sakler, Cincinnati, was re-elected president of the House of Delegates of the American Association of Ophthalmology at its recent meeting in Chicago.

* * *

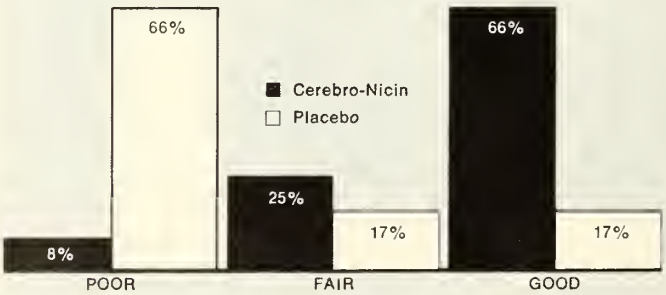
Dr. Jack Schreiber, Canfield, received the George Washington Honor medal and a cash award at the annual Awards dinner of the Freedom Foundation. He was especially cited for his speech, "The Last Candle."

For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin® capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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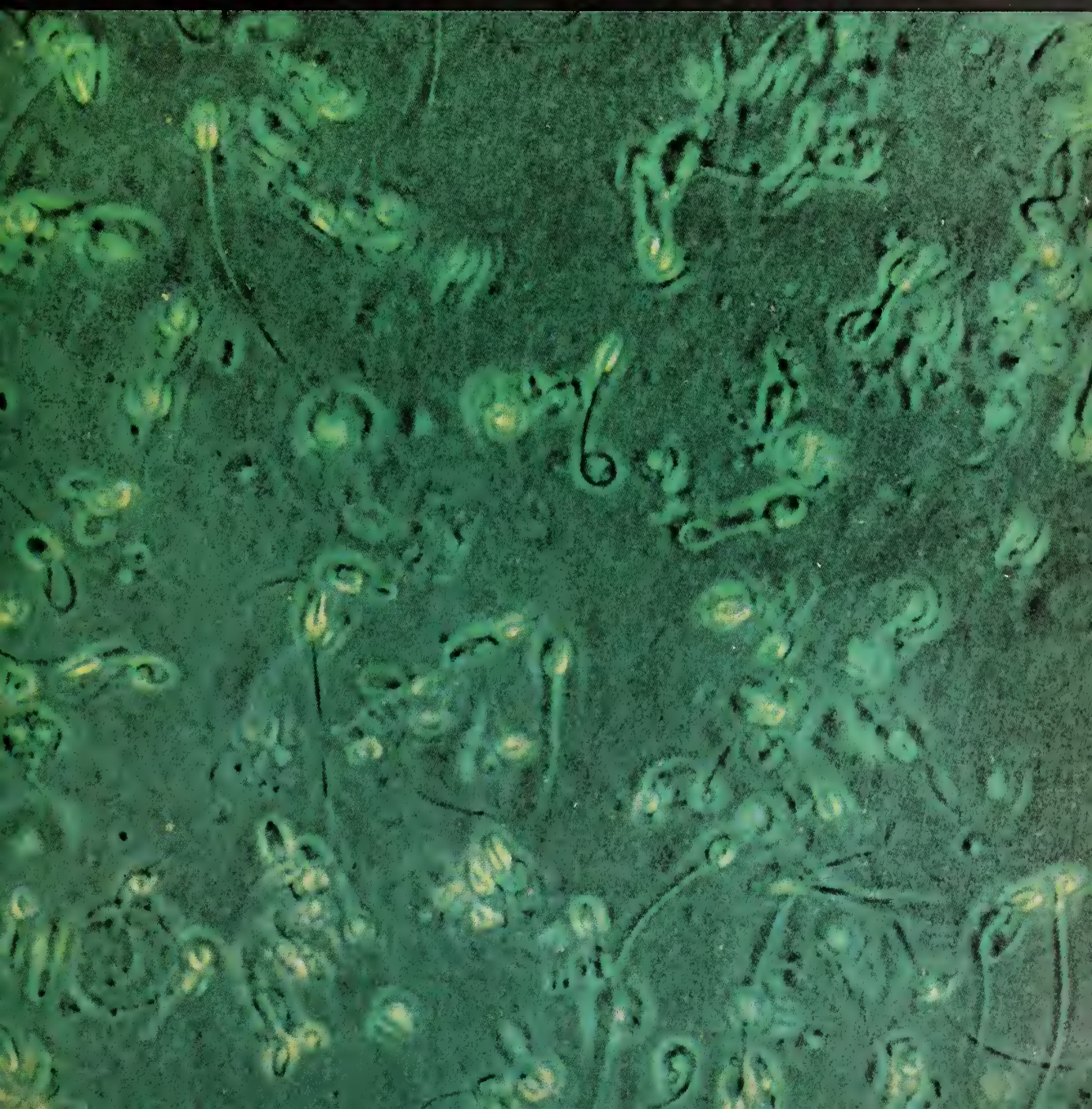
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When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidenc in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast change (tenderness, enlargement and secretion), change in weight (increas or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitislike syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, anc itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

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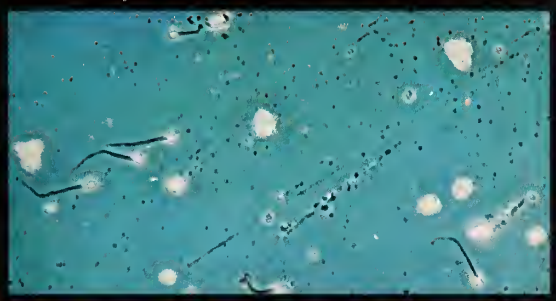
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

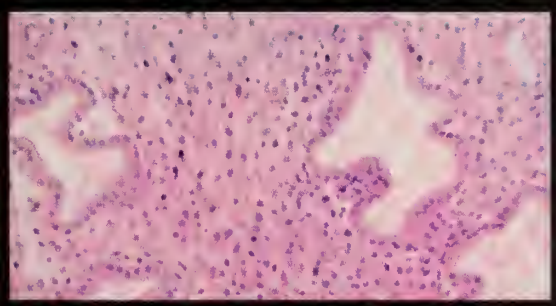
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

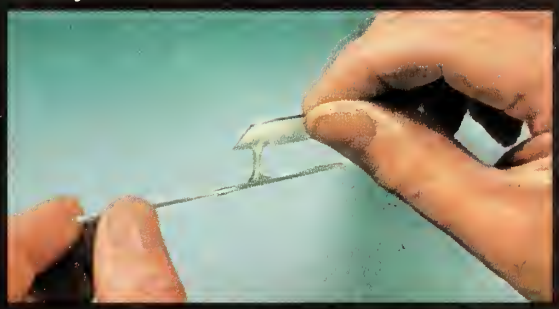


Spermatozoa appear healthy, active, freemoving.

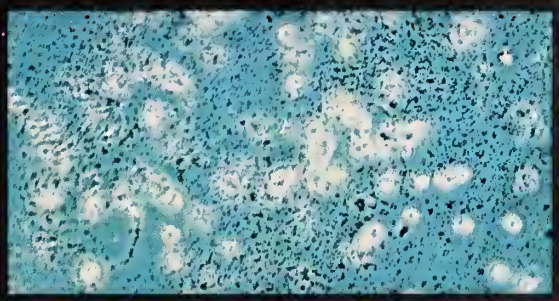


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

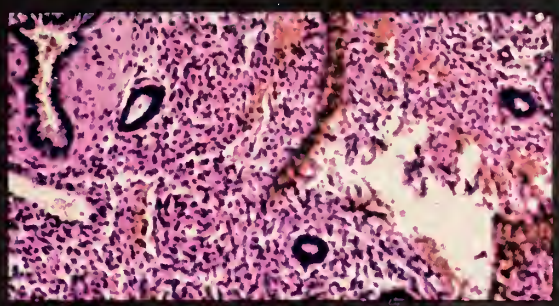
Norinyl-1 Patient



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Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



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Turn page for contraindications, precautions and side effects.

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Trends in Psychoanalysis

PAUL H. ORNSTEIN, M.D.

A BRIEF report on current trends in *therapeutic psychoanalysis* could best be undertaken by first considering the full range of the meaning of *Psychoanalysis* and then narrow it down to the therapeutic. Psychoanalysis is simultaneously: (1) a systematic theory of personality; (2) a method of psychologic investigation; and (3) a therapeutic technique. These three aspects of psychoanalysis are both historically and intrinsically intertwined. All three mutually influence and enrich each other. It is possible, however, with some measure of justification to talk about them as if they were separable. Yet, for the analyst engaged in therapeutic psychoanalysis, the three aspects represent more or less a unity.

We have to remind ourselves at this point that psychoanalytic theory and method had their beginnings in the therapeutic situation. Our experiences in that situation and the actual data we gather from psychoanalysis have not yet ceased to exert their effect upon theory, method and therapeutic technique. It is this empirical-experiential core and not the theoretic superstructure that represents the solid foundations of psychoanalysis and the wellspring from which innovations in theory and technique have emerged in the past and will hopefully continue to emerge in the future.

Contrary to generally held opinions, all three aspects of psychoanalysis have been in a continuous state of flux and development during Freud's lifetime and since. It is not my task to sketch this development and document the progressively evolving nature of psychoanalysis. I will only mention those changes that are relevant to a contextual understanding and appreciation of current trends.

The Author

● **Dr. Ornstein, Cincinnati, is Associate Professor of Psychiatry, College of Medicine, University of Cincinnati, and Assistant Director of Psychiatry Inpatient Service, Cincinnati General Hospital.**

1. *A Systematic Theory of Personality—A General Psychology.*

The early phase of psychoanalysis is often referred to as the period of "Id Psychology." There was dominant emphasis upon the newly discovered "Dynamic Unconscious" and its contents, the drives. This left many areas of personality structure and function outside of the realm of psychoanalytic interest. Expansion of the field of analysis occurred when Freud introduced the structural theory of the mind in his book on "The Ego and the Id" in 1923.

The introduction of the structural theory marks the beginning of the aspirations of psychoanalysis to become a *general psychology*. The period from 1923 to 1936 saw an almost equal emphasis upon the *Id* on the one hand and the *Ego* and *Super-ego* on the other in psychoanalytic theorizing and consequently also in therapy.

The reconceptualization of prior contributions in terms of the structural theory is still under way. Current trends include a comprehensive attempt by Rapa-

Presented at the 1967 Winter Meeting of the Ohio Psychiatric Association, February 22, 1967, in Cincinnati, Ohio.

port, [12] Gill[7] and more recently by Arlow and Brenner[1] to accomplish this task.

In 1936 with Anna Freud's "The Ego and the Mechanisms of Defense,"[4] the theoretical and clinical interest focused more intensively upon the Ego. The subsequent contributions of Hartmann,[8,9] Erikson[2,3] and Rapaport[11] further expanded the field of psychoanalytic theory and encompassed much of what was not contained in it before. As a result, they have paved the way for psychoanalysis to become a *general psychology*.

This means that psychoanalytic theory can now account for more than just the unconscious, drive-components of behavior. It has been expanded to also account for the interaction of these drive-components with the adaptive and defensive elements of behavior. Furthermore, it can account for behavior that is not rooted in conflict but originates in the conflict-free sphere of the mind.[9]

The significance of psychoanalysis as a general psychology then lies in the fact that it will now be possible to integrate the *motivational* and *learning* aspects of behavior under a single theoretical framework.

2. *A Method of Psychologic Investigation.*

Psychoanalysis as a *method* of data gathering is often referred to as "free association." This is such an oversimplification that it almost amounts to a distortion. The method, simultaneously investigative and therapeutic, encompasses much more than the so-called free association. A brief clarification is in order, since the misunderstanding of the nature of the method often leads to its misapplication and to unwarranted expectations.

This method can only be described by reference to (a) what the patient contributes to it; (b) what the analyst contributes to it; and (c) their relationship to each other and the total setting in which the whole process of analysis takes place.

Space permits only a rudimentary description, but this will also help us to define psychoanalysis as a therapeutic procedure.

The method of data gathering consists of assigning the patient the task of reporting freely all that he thinks and feels, completely honestly and without criticism. The analyst's complementary response to all of this is to listen with an "evenly suspended attention." Freud[5,6] characterized this kind of analytic listening by a suspension of judgment, by not directing one's notice to anything in particular and by an impartial attention to everything one hears. All of this takes place in the context of a unique relationship between patient and analyst; buttressed and in many respects even induced by the particulars of the setting, the common and constant features of the entire arrangement. This is not the time and place to detail these arrangements and their conscious and unconscious meanings, but permit me a word about the oft-ridiculed couch as one of the paraphernalia.

Irrespective of the historical reasons for its use, lying on the couch does, among other things, enhance the process of regression. It, therefore, permits the emergence of mental products that might otherwise be blocked from experience and expression. Everyone responds to this technical feature in a very personal, unique fashion. The difference in the form and content in the patient's experience is marked from the moment he begins the use of the couch. Yet, attempts on the part of many psychotherapists (medical and nonmedical) to get acquainted with this difference, by putting their patients on the couch, fail to elicit the desired response. They are then convinced that the couch makes little, if any, difference. This also applies to other individual details of the arrangements that one might want to experiment with. My point is that it is the *total context* with all of its details that constitutes the analytic method of which "free association" is one aspect, and *only* the simultaneous application of them induces what we call the analytic process and gives us the analytic data.

Experiments with the method and setting are few and far between, but this problem area is not directly related to our present topic.

3. *A Therapeutic Technique.*

Now we are ready to consider therapeutic psychoanalysis. The problem is, however, that if you consult the literature, you will find that there is no clear-cut agreement as to what constitutes an analysis. There are few publications that deal with it *in toto*; most of them deal with one or another of the important component segments of the analytic process.[10]

During the different developmental phases of psychoanalysis, the answers to the question of what is analysis were given differently, based on the prevailing theories. Since the theory has changed and is changing in the direction I have already indicated, the definition of psychoanalysis as a therapeutic procedure has also changed and is changing in the direction which I will now describe.

Initially, analysis aimed at making the unconscious conscious, and to reconstruct the genetic trauma. Later on the aim was to change the interrelations between the id, ego and super-ego; to alter the defenses and strengthen the ego to tolerate id derivatives; to influence the super-ego toward increasing tolerance and especially the idea of the resolution of the transference neurosis—to name only a few.

Now analysis is seen as much more than embracing all of the aforementioned aims and the technics developed for their implementation. Let me give a more up-to-date version of what therapeutic psychoanalysis is. The psychoanalytic situation and method, as I have described them, if properly instituted, set off and maintain the analytic process. This consists of two separable processes: (1) the moment-to-

moment, hour-to-hour dynamic movements in the analyst-patient relationship; (2) the recapitulation of infantile conflictual experiences in the transference neurosis.

The first of these processes consists of current conflicts in the patient activated in the analytic situation vis-a-vis the analyst. At first these are defenses against the regression to which the situation and method invite the patient and toward which he has enough of an intrinsic pull anyway. This part of the experience is referred to as the "Defense Transference." Later on when he can permit himself this regression, the patient will re-experience his infantile developmental conflicts vis-a-vis the analyst. This part of the experience is called the "Transference Neurosis."

The analyst's active contribution (beyond the setting and method) is in the form of empathic resonance with the patient's experiences and interpretive interventions that help to *establish, experience fully and deeply* and then *resolve* the transference neurosis. It is this transference neurosis that is at the core of psychoanalytic therapeutic activity and its resolution is the means whereby psychoanalytic therapeutic results are achieved.

How are they achieved? During the initial phase, the analyst's interventions aim at helping the patient to develop the capacity to observe himself as he experiences himself in this new context. Analytic work requires that this observing part of the patient enter into an alliance with the analyst to perform the task of self-observation and to communicate these self-observations in the form of free associations. This task for both patient and analyst continues throughout the analysis, but it is central at the beginning.

Soon the patient will turn in a characteristically unique fashion, in his attitude and behavior, against the pull of re-experiencing with the analyst his infantile conflicts. The analyst's interpretive interventions will be aimed at recognizing the current meaning and purpose of this defensive behavior; *how* is the patient defending himself, against *what* and *why?* This interpretive process slowly and piecemeal removes the obstacles from a more or less intense re-experiencing of early developmental conflicts. Once this stage is reached, patient and analyst are in the midst of a transference neurosis. This means that the patient is now in the throws of experiencing the analyst as one of the key figures of his early childhood. The patient is now bent on re-experiencing the past in the present, rather than remembering what he once experienced. His task requires the analyst to perceive the role in which the patient casts him, and he has to sense precisely what the patient expects of him in this role.

Sensing and interpreting rather than gratifying the patient's wishes and expectations in the transference is the mode whereby the analyst can contribute to the resolution of the transference neurosis. This resolution permits the patient to see the remnants of his infantile conflicts with his infantile objects to have inappropriately intruded into his adult relationships, and he can now more distinctly differentiate between the past and the present.

This atrociously condensed and abbreviated presentation should serve as a background for exemplifying current therapeutic trends in psychoanalysis.

Let us briefly consider how the analyst of the sixties would *select* and *treat* his patients as compared to his colleague of the thirties. This will enable us to focus on the sharpest differences, even though these have come about in the form of a *gradual* evolution.

A Clinical Example

A 40 year old married man, father of two boys, sought analysis for a very disturbing sexual perversion after trying a number of other therapeutic methods including psychotherapy, drugs, and Sodium Amytal® interviews. He was then told that psychoanalysis could help him in a more fundamental, rather than merely symptomatic fashion, and he waited for analysis impatiently for about one and one-half years.

He is intelligent, expressive, with a good amount of self-awareness. His near fundamentalist-provincial views were in conflict with a somewhat more liberal outlook and an attempt to see himself and others from a broader perspective. He considered himself enslaved to his sexual practices in which he indulged with varying frequency from early adolescence. Lately these have become more frequent and began to interfere with his work which can best be described as a combination of public relations and social work. Since his time is largely his own, he spent more of it by indulging in his perversion than productively on the job. When this began to threaten his performance more seriously, he sought analysis.

In the diagnostic interviews he presented his desire and need for analysis and his readiness to undertake it without hesitation — almost too much so.

As soon as he was on the couch which he began to use somewhat reluctantly, his fears, concerns, doubts and hesitations came to expression in many different forms and in varied contexts. Some of these feelings became perceptible to him, but others were expressed without his explicit awareness.

His immediate associations also revealed intense loneliness, which has apparently been his lot ever since he was a small boy. He launched into great details about his sexual practices. He was expressive and introspective about them and supplied many historical details that began to shed some light on the possible genetic origin of his complex symptoms. The way he practiced his perversion currently, especially the timing of it, began to show how he felt about analysis and the analyst. It also revealed one of the purposes for which he was now using his symptoms and the detailed descriptions of them.

He began to come 10, 15, 20 minutes late or missed his session entirely, because he felt compelled to indulge in his sexual practice, which prevented him from arriving at the office at the appointed time.

A discussion of this vignette should highlight current ideas about indications, contraindications and strategies in psychoanalysis.

Indications and Contraindications For Psychoanalysis

The patient was chosen for analysis because his symptoms were all-pervasive, affecting his work and love life, his self-esteem and his self-confidence. These were of long duration, probably manifest since early adolescence. In spite of this profound

disturbance, the patient was able to prepare for and pursue a career, and was able to marry, sustain a marriage and have two children. He showed good motivation for change and seemed able to accept and live up to his part of the analytic contract. He had a certain amount of objectivity about his illness and was able to discuss what he knew. From his waiting for analysis for one and one-half years and other data, it seemed that he also had some ability to tolerate frustration.

The characteristics just enumerated would have made this patient a good candidate for analysis in the past, as much as in the present. As a matter of fact, these criteria for analyzability serve as better guidelines for analysis as a method of choice, than do the older notions that the hysterical and compulsive patients are best suited for this treatment. The clinical categories matter little and if the foregoing characteristics are present, the suitability depends more upon motivation, a certain amount of stability in the patient's external circumstances and the existence of the kind of long-standing conflicts and problems for which the expenditure of time, effort and money seems commensurate. In other words, situational, acute, crisis-type problems do not need to be considered for analysis. Current trends in broadening the criteria include patients with psychosomatic problems, certain character disorders and even borderline patients, who are often prepared for an analysis by a preliminary psychotherapeutic approach.

Contraindications include patients with severe ego-distortions, acute or chronic psychoses and certain types of psychopathic character disorders.

Changes in Analytic Strategy and Focus For Interpretations

Regarding the patient in our clinical vignette, the analyst of the thirties immediately would have been interested in where his symptoms came from, which of his drives were deflected, from what object and from what aim, and what prevented this patient from reaching a mature, sexual development. The patient would have gladly gone along with the analyst's reflections on the nature and origin of his symptoms, and use this as a defense against getting involved with his analyst. Interpretations about the nature of the patient's drives, with the intention to bring the repressed to awareness, would have been the strategy; mixed with interpretations regarding the genetic origins of the symptoms and behavior and little interpretive attention to the process of analysis.

The analyst would have expected that transference feelings and distortions would inevitably develop and their interpretation and resolution would aid the achievement of analytic cure. The need for the so-called "transference neurosis" was not yet considered by all analysts to be a *sine qua non* for analytic results.

In contrast, the analyst of the sixties would immediately concern himself with the communicative value of his patient's behavior and symptoms. In our case, this would mean attention to how and for what particular purpose the patient used his symptoms and his verbal and nonverbal communications to the analyst. He would also pay attention to how his wish for closeness and dread of closeness alternated and how he used unconsciously his symptoms to achieve both of these ends.

The patient talked at length about his symptoms to get his analyst involved in them, just as he got his mother involved in his matsurbatory activities as a child. He was then provoking closeness (mother was interested in checking him frequently) and distance (she scolded and threatened him when he continued with his habit). The analyst kept the genetic connections in his own mind and focused his interpretive comments on the patient's emerging fears, concerns, doubts and hesitations regarding the analysis and the analyst. He made no comments other than asking a few questions regarding the perversion. This led to increasing frustration and anger in the patient. At the appropriate moment, the analyst interpreted that the patient was furious about what he thought was the analyst's lack of interest. The patient confirmed this by saying that his *major* concern was his perversion and the adverse effects of it upon his life, and the analyst did not seem to take it seriously enough since he made no comments about it.

Following this interpretation, his symptoms decreased to the patient's own amazement, but he began to come late or miss a few of his sessions completely. It was as if he were saying, "If you don't take my symptoms seriously enough, don't get involved in them or upset about them, maybe you will if I come late or don't show up—that will get to you!" After this too was interpreted, the patient began to look at his behavior in the analysis and to put more of his feelings into words. He missed less of his sessions and came late less frequently.

This manner of initiating the analytic process helps the patient to develop the capacity to observe what he is experiencing and to allow the observing part to become the analyst's partner in the joint effort at analysis, which we now refer to as the therapeutic alliance.

Concomitant with this development, the patient resists against allowing himself to use the analyst as an object with whom to repeat his early conflicts and find new solutions for them. As the analyst consistently and repeatedly interprets this behavior and the purposes it serves, the patient further regresses in the analytic situation and repeats some of his early traumatic and conflictual experiences with the analyst. This is the transference neurosis, which serves as the vehicle for the achievement of emotional insight, and it also permits the removal of some of the obstacles from further maturation and development.

The attention to this total process rather than merely to the content or the drives also permits

the handling of termination differently from before. It is easier to find signs and signals first of a backward movement (regression) and then of forward movements (progression) along developmental lines. Regression and progression alternate many times during the middle and the end phase of analysis, until progressive movements and a giving up of older emotional positions dominate the scene. Charting the course of what goes on between patient and analyst along the lines of what is repeated from early childhood or adolescence provides a map of indicators for termination, rather than let the analysis peter out or terminate it arbitrarily.

Having reviewed current trends in psychoanalysis from the vantage point of a practicing psychoanalyst, it would seem unnecessary to add an epilogue, making some judgments about psychoanalysis as *theory, method* and *therapy,* were it not for sharply contradictory notions about it among psychiatrists as well as the general public.

As a *theory*, psychoanalysis has been confronted by other theories, but none of them equally encompassing about the human condition. Psychoanalysis has claimed its all-inclusive applicability to the study of man, and in the words of Rapaport: "There is sufficient evidence that the claim has a substantially valid core."[12]

As a *method* of psychologic investigation, psychoanalysis has obtained and continues to obtain data that expand our understanding of man. The use of some aspects of the method in what is called applied psychoanalysis ranges so broadly as to include history, literature, the arts, religion and many more areas of human endeavor.

As a *therapeutic technique*, its broad scale applicability has remained limited, if we look upon applicability in pure quantitative terms. There has been an expansion from its primary domain of the hysterias and compulsions, across clinical categories, to include a variety of character disorders, psychosomatic problems and even some borderline personalities, clearly indicating a *widening scope* even of therapeutic psychoanalysis. These expansions have brought with them new understanding of the nature of illness, especially as these involve the ego and super-ego functions. Thus, progress has been made even in the area of treatment along with the recognition of new difficulties and new therapeutic challenges.

In addition to developments within its own domain, psychoanalysis importantly influenced psychotherapy, case work and counselling. Its therapeutic effectiveness filtered down to these other methods—methods which themselves have expanded in response to cross-fertilization with psychoanalysis. This last point is especially important at a time of increased service demands upon the psychiatric profession.

Because of these increasing demands, psychoanalysis is often castigated for its concentration upon and seeming preoccupation with the individual. Yet, I venture to say, our most important insights into human problems and the continued development of technics for dealing with them still originate in our therapeutic relationships with the individual. Only if our therapeutic attitudes and technics remain firmly anchored in our extensive experience with individuals, can we be secure that developing technics for dealing with problems on a larger scale will not become dehumanized.

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THE ART OF MEDICINE, like any other form of art, must comprehend the relevant application of scientific or technical disciplines. There is no evidence whatsoever that technical mastery dehumanizes medical students provided that it is acquired in a place where medicine is practised with humanity, and where teachers accept personal responsibility for the care of their patients. — Alastair Hunter, M. D., F. R. C. P., London, England: *British Medical Journal,* 2:552-557, September 4, 1965.

An Isotopic Method for the Study Of Carotid Circulation

JACK MARKS, M.D., WILLIAM J. DORSON, JR., PH.D., and DENES B. HUNKAR, D.E.

THE MANY investigators who have applied radioisotope tracer technology to the study of cerebral circulation have provided a compendium of basic information and applied techniques that have diagnostic value relative to the stroke problem and other brain disorders.[1, 2, 7]

In this relatively early phase of the radioisotope technology, no standard instrument system or standard test method for the study of brain circulation has yet evolved, nor does such seem likely within the immediate future. Rather, it presently remains for each laboratory group to formulate a specific test method and to draw conclusions germane to the method and instrument system employed. In this communication, we wish to describe an instrument system and a theoretical model, which is used to interpret the clinical observations and to assess the validity of the general measurement method. Our particular interest is related to the study of the carotid artery blood flow and to the recogniiton of patients with asymmetrical flow dynamics. These observations, however, are applicable to the measurement of blood flow in other areas of the body.

As a bolus of radioactivity passes through the brain, a characteristic accumulation of counts over a time base is obtained from scintillation detectors that view such an event. Such a bolus can be introduced into the brain circulation by intra-arterial injection[3,4] or by an antecubital intravenous injection.[5,6,9] In the former instance the bolus is more discrete and passes through the field of observation as a "slug" of radioactivity. When the bolus is introduced intravenously, there occurs a great lengthening of the tracer as it passes through the cardiac and pulmonary circulations. Even so, the shape of the bolus retains a characteristic form, having a leading edge, then a part of greatest radioactive density, or centroid, and a long trailing portion. The centroid reappears upon exit from the brain and is super-

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The Authors

- Dr. Marks, Columbus, is Chief of Medicine, St. Ann's Hospital; Research Associate, The Columbus State Hospital; and a member of the Active Staffs of Grant Hospital, and St. Anthony Hospital.
- Dr. Dorson, Tempe, Arizona, former Instructor, University of Cincinnati and Consultant, Good Samaritan Hospital, Cincinnati, presently is Associate Professor, Arizona State University and a member of the staff, Arizona Kidney Foundation.
- Mr. Hunkar, Cincinnati, is a member of the Faculty, The University of Cincinnati; Research Associate, Department of Nuclear Engineering.

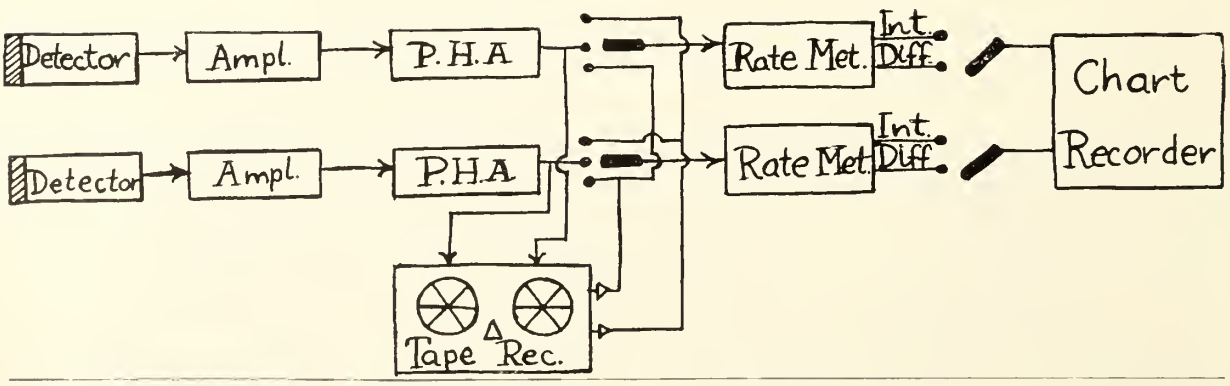


FIG. 1. *See Text (Experimental Procedure).*

imposed upon the long trailing portion of the bolus. Shortly a relatively constant level of radioactivity remains.

Oldendorf[7, 8] recognized the great value of examining the first derivative of such a curve. ie., its rate of change. This first derivative is, in the context of fluid dynamics, an expression of flow velocity. Oldendorf[8] employed the first derivative of the basic integral data to identify the densest part of the bolus of radioactivity as it traversed the brain. In his experiment,[8] when the densest part of the bolus or its centroid entered the brain and the field of view of the scintillation detectors, a sharp upward sweep of the recorder was noted. As the centroid left the brain, a negative deflection was recorded. Given these two deflections upon a steady time base, the mean transmit time of the centroid through the brain was determined, a value of 6.5 to ten seconds in normal subjects and up to 18 seconds in patients with cerebral vascular disease or with increased intracranial pressure. The basic method of using the first derivative was also employed by Oldendorf[7] to measure cranial flow asymmetry.

While the application of the first derivative to identify the entry and departure of the bolus served a very useful purpose in Oldendorf's study,[8] we have focused our attention upon the entry of the bolus into the field of view. We believe that this entry phenomenon as delineated in the first derivative offers the most useful information from the point of view of carotid artery circulation and represents the part of the curve least influenced by recirculation and other artifacts. We believe that during the entry of the bolus there can be observed data most suitable for qualitative comparison of one side with the other. It also seems the portion of the curve most promising to yield quantitative measurement of flow velocity of the individual carotid arteries.

While asymmetry of cerebral flow has been recognized as a normal variant[1,8], we believe that it remains to be established whether normal variation can be distinguished from the aberrant changes incident to the occlusive disease of the carotid arteries.

Boczko and Caplan[11] have recently demonstrated by percutaneous retrograde arch aortography that in the presence of major stenosis of the internal carotid artery, defined by them as a reduction in measured luminal diameter greater than 50 per cent, that in the great preponderance of the patients comprising their series of cases, there was a 0.5 second, or greater, delay in linear flow of contrast material through the stenosed carotid artery as compared with the contralateral one. Our method seeks to delineate such differences in flow velocity by isotopic flow monitoring at the neck and base of the skull.

Experimental Procedure

Our instrument system consists of two scintillation detectors with 2 inch by 2 inch sodium iodide



FIG. 2. *Left carotid angiogram with obstruction of left internal carotid artery. The external carotid circulation is demonstrated beyond the point of obstruction.*

(NaITl) crystals surrounded by circular lead shields having 2 inches of lead around the detectors, leaving exposed the front surface of the crystals. The outputs of the detectors are fed through dual channel amplifiers and pulse height analyzers, permitting us to work with counts appearing at energies lying only under the photopeak of the isotope. The outputs of the analyzers are recorded directly on a high speed magnetic tape and are connected to a dual-channel ratemeter so that, during the passage of the bolus in the field of view of the detectors, we secure an analog display on the chart recorders while the count-time relationship is recorded on the tape.

Thirty seconds after injection of the radioactive tracer, we obtain all the test data we require. At playback the tape recorder is slowed down to provide a time expansion for more accurate analysis. During playback of the tape, the outputs are fed into the ratemeters. Each of the ratemeters has two modes of display: an integral count rate and a derivative indicating the rate of change of the integral count rate. The data can be played back so that each channel can be employed to play the integral count rate. The data can be played back so that each channel can be employed to play the integral or first derivative of either side. This compensates for instrumental errors. (See block diagram, Fig. 1.)

Differentiation of analog data is difficult to obtain, since the statistical variation causes the derivative to

fluctuate. For measurement of the derivative, a reference line is necessary to correlate all results. Since our early circuit components leaked, the derivative started at an intercept point other than at absolute zero on the recorder. In order to insure that the amplitude was measured from a point where all components had come into equilibrium, we later designed a special differentiating circuit that used a very accurate reference voltage. Against this voltage, we can calibrate the output of the derivative circuits, thus permitting us knowledge of the relationship between the reference voltage and the status of the derivative circuit.

This method of differentiation, together with the time expansion and self-error cancellation through the use of cross channel functions, provides us with an accurate means of establishing the amplitude of the first derivative.

Our studies have been performed in three phases. In our first experiments we calibrated the derivative utilizing a single tygon tube positioned between the two scintillation detectors. At controlled flow rates sodium iodide-131 was injected, and the height of the derivative was plotted against the volumetric flow rate. In these tests, a linear relationship was observed between the height of the first derivative and the flow rate of the liquid. These tests provided us with an ideal geometry to calibrate one channel against the other, since the two detectors were looking isogeometrically at the same phenomena.

In the second set of laboratory experiments, we employed a human skull with tygon tubing placed in the foramina of the carotid arteries. The two scintillation detectors were placed on opposite sides of the skull, thus providing us with controlled geometery. Flow rates were plotted against the derivative of both sides. Very close linear relationship was observed between the flow rates and the height of the derivatives on their respective sides.

Clinical Application

In our clinical cases, patients were studied in supine body position. Each of the two scintillation detectors was placed in symmetrical position adjacent to the parietal portions of the skull. An injection of 75 microcuries of 131-iodine-Hippuran® was made into an antecubital vein of one of the arms by a method that permits discrete insertion of a bolus.[9] The tape recorder was started at the time of the injection. The pulse height analyzers were previously calibrated to observe only the energies lying within the photopeak of iodine-131. The outputs of the pulse height analyzers were recorded on the magnetic tape and into the ratemeters in the integral display mode. Thus, the passage of the bolus within the field of the two detectors was observed on the chart recorders. Approximately 30 seconds after the injection, the tape recorder was stopped and the data played back with a time expansion factor of

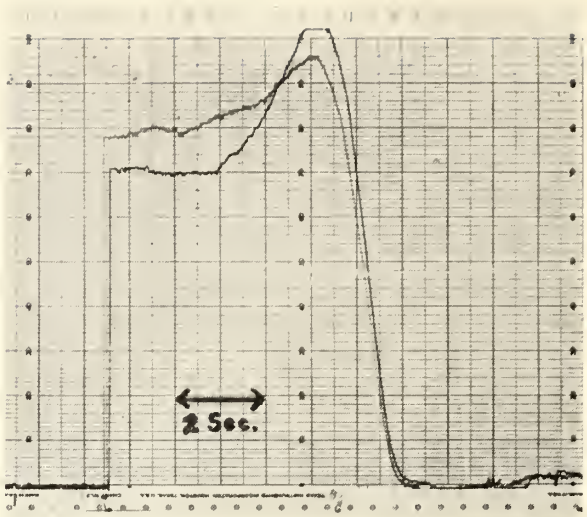


FIG. 3. *The higher curve was obtained from the patient's obstructed left side.*

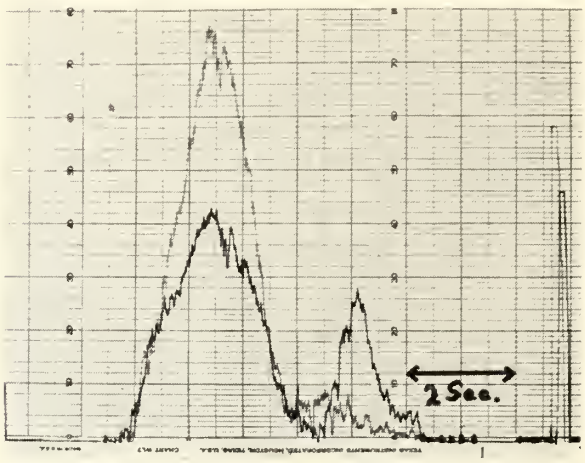


FIG. 4. *The higher curve was obtained from the patient's unobstructed right side.*

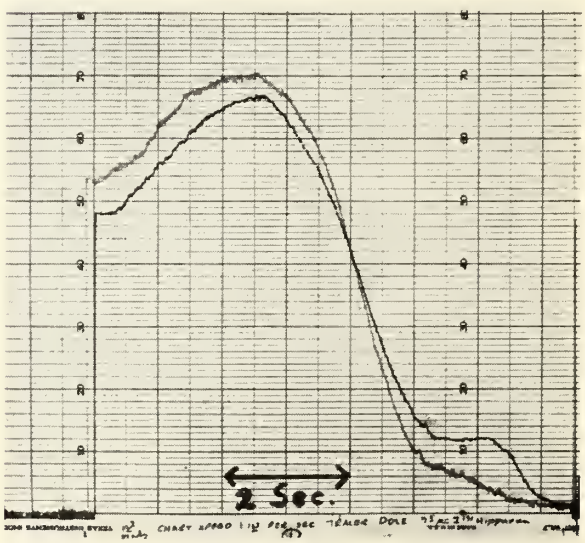


FIG. 5. *The higher curve was obtained from the patient's unobstructed right side. (Second Test.)*

"four" in the integral mode and subsequently in the differential mode. This permits us to observe the maximum rate of change during the upsweep of the integral curve.

Case Report

A 60 year old right-handed man complained of a transient episode of right-handed weakness and speech aphasia. On physical examination, a bruit was heard over the left side of the neck along the course of the carotid artery. No lateralizing neurologic signs were elicited.

The patient was admitted to Grant Hospital, where a left-sided percutaneous carotid angiogram was made. (See Fig. 2.) The angiogram revealed obstruction of the major portion of the left internal carotid artery. Collateral circulation between the ophthalmic artery and the distal portion of the internal carotid artery was noted.

In a study of the patient's carotid flow dynamics, the patient was placed in a supine position and a scintillation detector was placed over each of the carotid arteries near the base of the skull. Seventy-five microcuries of 131-iodine-Hippuran was injected discretely into an antecubital vein.[10]

The integral data showed a greater peak counting rate on the obstructed left side. (See Fig. 3.)

When the first derivative of the integral data was recorded (Fig. 4), it was seen that the rate of change of the initial upsweep was more rapid on the unobstructed side, representing a greater velocity of flow on the unobstructed side. The test was repeated, similar in every respect, except for a change in the placement of the scintillation detectors. On this run the integral data showed the greater counting rate on the unobstructed side (Fig. 5).

The first derivative (Fig. 6) again reflected the greater velocity of flow on the unobstructed side. This verifies the greater consistency of the first derivative in recognizing differences of velocity as compared with the integral data and illustrates its relative insensitivity to changes of geometry.

Normal Subject

In a subsequent study performed on one of our own staff, there was recorded a difference in height (offset in the integral counting rate) obtained from the right and left sides of the head (Fig. 7).

The first derivative of these data showed essentially equal velocity of blood flow into the two sides of the head (Fig. 8).

Conclusions

A method has been described which attempts to delineate the differences in velocity of blood flow attributable to occlusive vascular disease in anatomically symmetrical arteries. This method is based upon instrumental determination of the first derivative of the counting rate of a discretely introduced radioactive bolus. The brief period of measurement precludes influences of recirculation and internal convection effects.

Further work is planned in extending and refining the technique presented herein. The method has promise of providing valuable diagnostic data in the study of circulatory disorders.

Acknowledgments:

This work was supported by a Grant from The Central Ohio Heart Association. Various aspects of the work were completed at Grant Hospital, St. Anthony Hospital and University Hospital, Columbus, Ohio, and in the Departments of Nuclear Engineering and Chemical Engineering, The University of Cincinnati, Cincinnati, Ohio.

We wish to acknowledge gratefully the support of Dr. Paul Neumerof of E. R. Squibb and Sons who provided us the radiopharmaceuticals employed in this investigation. Mr.

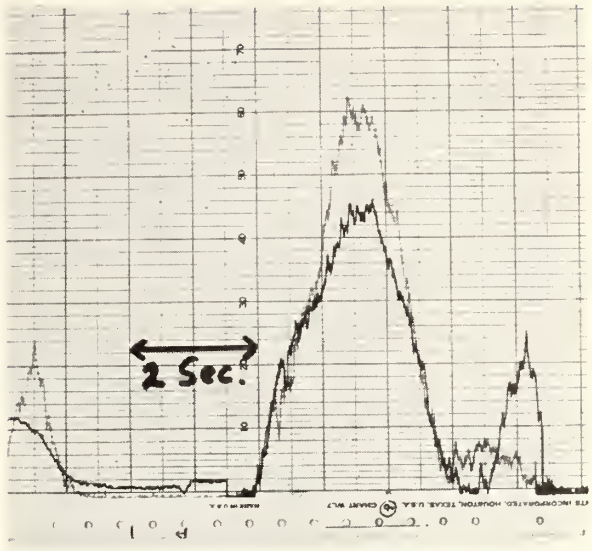


FIG. 6. *The higher curve was obtained from the patient's unobstructed right side. (Second Test.)*

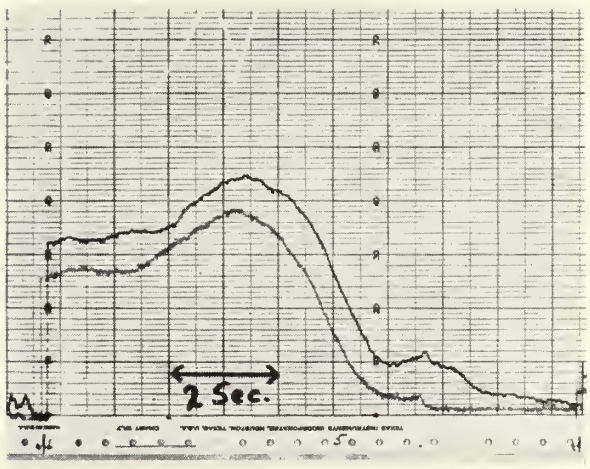


FIG. 7. *NORMAL MAN. Upper curve is from the right side of head.*

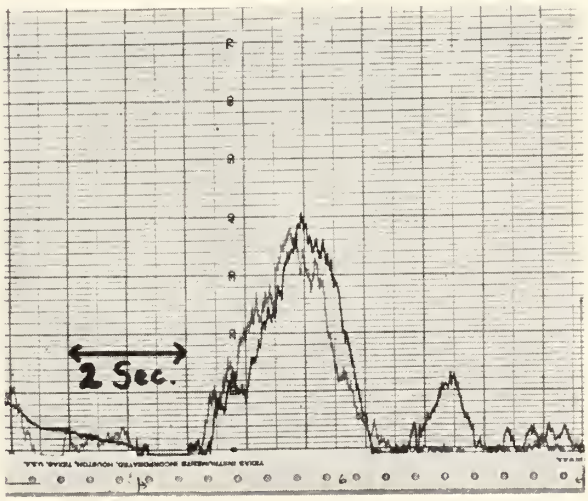


FIG. 8. *NORMAL MAN. Essentially equal velocity of blood flow is noted into the two sides of the head.*

Henry Reid rendered invaluable technical assistance in the performance of these studies. Mr. Mark Manoff of the Department of Chemical Engineering, The University of Cincinnati, provided us with valuable assistance in the calculations which were performed.

We also acknowledge gratefully the assistance of Dr. William E. Hunt, Department of Neurosurgery and Dr. Chester C. Winter, Department of Urology, The Ohio State University Hospital, for their assistance in this study and finally, we wish to express our appreciation to Dr. Warren G. Harding, Administrator of Grant Hospital, Columbus, Ohio, for his interest and encouragement.

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VENTRICULAR TACHYCARDIA-FIBRILLATION. — A patient had over 200 episodes of paroxysmal ventricular tachycardia-fibrillation after infarction despite suppressive drug therapy. He was converted successfully each time with D-C shock (for the most part by the nursing staff), eventually making a complete recovery despite several complications. No detrimental effect of these numerous shocks was observed. It appeared that large doses of cortocosteroids were helpful in suppressing the arrythmias. — Gerald Alexander, M. D., Miami Beach, Fla.: *Southern Medical Journal,* 60:118, 123, Feb. 1967.

BEHAVIOR OF XYY MALES. — The behavior of nine male patients with an XYY sex chromosome complement has been analyzed and assessed. It was found that *(a)* they suffered from a severe disorder of personality, in most instances associated with intellectual impairment, which it is suggested is due to the extra Y chromosome; *(b)* in their criminal behavior they displayed less violence against persons than did control patients; *(c)* they began their criminal activities at a very young age, on average five years earlier than other patients at the hospital; *(d)* they had no significant family history of crime or mental illness; and *(e)* their criminal behavior had proved in the past to be resistant to conventional forms of corrective training and treatment. — W. H. Price, M. B., B. Sc., M. R. C. P., Edinburgh, and P. B. Whatmore, M. B., LL. B., D. P. M., Carstairs, Lanarkshire, Scotland: *British Medical Journal,* 1:533-536, March 4, 1967.

Percutaneous Needle Biopsy Of the Kidney

A Discussion of Indications and Applications

FRANCIS E. CUPPAGE, M.D., and EDWIN J. SMITH, M.D.

GREAT STRIDES have been made during the last 15 years toward the understanding of many renal diseases. Improvements of instrumentation and the development of many therapeutic drugs have advanced diagnosis and treatment of many important kidney disorders. The refinement of the technic of renal biopsy has been no exception. As early as 1923 Gwyn[1] advised open biopsy of the kidney during surgical exploration. Others, including Russell,[2,3] studying glomerulonephritis and Castleman and Smithwick[4] studying hypertension, advocated surgical, or open, renal biopsy for the diagnosis of renal disease. In 1950 Perez[5] first reported that biopsy by the percutaneous method was safe. Then with reports by Iversen and Brun[6] in 1951 and by Alwall[7] in 1952 systematic percutaneous renal biopsy became an established procedure. Since then percutaneous renal biopsy has become a frequently used aid for the diagnosis and treatment of a variety of renal diseases, and several excellent monographs[8-13] have been written on the subject. This report has been written as an attempt to review the indications, applications, and limitations of the renal biopsy. The discussion will be limited to the percutaneous method of biopsy.

Purpose and Indications of Renal Biopsy

Paramount to the use of renal biopsies is an understanding of their purpose and effectiveness. In general, renal biopsies are obtained in order to answer specific questions for the physician treating the patient. A renal biopsy is usually performed for one of the following reasons: (1) to establish or confirm a diagnosis in a case that is confusing from the clinical aspects, (2) to direct therapy, (3) to determine the stage of a given disease process, (4) to evaluate additional underlying renal diseases that might affect recovery, (5) to estimate the reversibility of a process in order to aid in making a prognosis, and (6), perhaps least frequently but still importantly, to add knowledge concerning various aspects of the pathogenesis and etiology of renal disease. Usually history and previous examinations of the patient have narrowed the diagnosis so that only specific questions are asked of the biopsy. The indications for a renal biopsy, therefore, usually fall into one of three categories: diagnosis, choice of therapy, and prognosis including the establishment of the amount of reversibility and the stage of the disease.

Diagnosis. A renal biopsy is often of particular help in the establishment of a specific diagnosis in patients with the nephrotic syndrome or with asymptomatic proteinuria. A biopsy is often useful in distinguishing the type of glomerulonephritis, such as proliferative or membranous glomerulonephritis (Figs. 1-6), which in general have different courses and prognoses. In addition a renal biopsy might suggest a specific diagnosis as yet unsuspected in patients with amyloidosis, diabetic glomerulosclerosis (Fig. 7), lupus erythematosus, or polyarteritis. Recently, renal biopsies have been shown to be useful in establishing diagnoses in patients with congenital nephritis (Fig. 12).[14,15] The fact must be kept in mind, however, that the kidney can only react to injury in a limited number of ways. Although at times the pattern of changes may be characteristic of a particular disease process, often only a group of diseases is suggested which cannot be distinctly separated by examination of the renal biopsy alone. In the latter stages of the course of many progressive

The Authors

● Dr. Cuppage, Kansas City, Kansas, former Assistant Professor of Pathology, Ohio State University, is now a member of the Department of Pathology, University of Kansas Medical Center at Kansas City.

● Dr. Smith, Columbus, is Assistant Professor, Department of Medicine, Ohio State University and Director, Ohio State University Renal Dialysis Laboratory.

From the Departments of Pathology and Internal Medicine, The Ohio State University College of Medicine, Columbus, Ohio. Submitted May 22, 1967.

renal diseases the kidneys become scarred and atrophic, and often at this time no definitive etiology can be placed upon the renal alterations.

Choice of Therapy. Knowledge concerning the response of specific forms of glomerulonephritis to certain agents such as steroids and immunosuppressors has led to the necessity for correctly establishing the nature of the disease by renal biopsy. One can now better predict the likelihood of response in a given case of glomerulonephritis and perhaps save the patient unnecessary exposure to courses of potentially toxic drugs. For example patients with the nephrotic syndrome associated with minimal membranous glomerulonephritis respond better to steroid therapy than patients with marked membranous or with proliferative glomerulonephritis.

Prognosis. A renal biopsy is often indicated in the patient with acute anuria. In this instance, a renal biopsy will help to confirm the type of injury, i.e., toxic or ischemic tubular injury or occasionally glomerulonephritis. More importantly, careful examination of the biopsy specimen will help to determine the reversibility of the changes and the ability of the kidney to restore its structure and function (Figs. 8-10). The estimation of the degree of reversibility is important in the decision as to whether or not peritoneal or hemodialysis should be undertaken.

The degree of reversibility can also often be estimated in glomerulonephritis. Crescents and glomerular obliteration are usually considered irreversible, while glomerular cellular proliferation alone is often completely reversible. The estimation of the degree of such changes is important in predicting the course of the disease in any given patient.

Under certain circumstances, renal biopsy may be helpful in the evaluation of hypertension (Fig. 11). The formation of the hypertension-associated hormone renin by the juxtaglomerular cells of the renal glomerular hilus has been established. Several technics have been developed to stain the renin-containing granules of these cells. [16,17] Although the exact nature of the stimulus for the secretion of renin is as yet incompletely understood, a definite relationship exists between renal hypertension and the amount of renin secreted by the kidney.[18,19] Using special stains, a careful evaluation of the juxtaglomerular cell index, or amount of renin granularity, is often helpful in evaluating the kidney as the etiologic agent of hypertension. In addition, Vertes et al. have used bilateral renal biopsy in the evaluation of hypertensive patients who are suspected of having reparable renal artery disease in order to exclude irreversible intrarenal vascular disease.[20] This is important because surgical cure of hypertension resulting from main renal artery disease can be attained only if both kidneys are uninvolved with intrarenal arterial disease that might prolong hypertension or decrease the recoverability.

Contraindications and Complications Of Renal Biopsy

Several fairly specific contraindications to renal biopsy include the uncooperative patient, the patient with only one kidney, and the patient with a bleeding disorder. Both severe hypertension and uremia increase the risk of biopsy because of the increased

FIG. 1. *Acute proliferative glomerulonephritis in a 56 year old man who was admitted with thyrotoxicosis and acute renal failure. Two glomeruli contain an increased number of endothelial and mesangial cells with polymorphonuclear leukocytes. Adhesions are present between the glomerular tufts and Bowman's capsule. Hematoxylin and eosin. X 170.*

FIG. 2. *Resolving glomerulonephritis in a 14 year old girl treted with Imuran for acute proliferative glomerulonephritis. Only focal slight hypercellularity is present within the glomerular tufts. Hematoxylin and eosin. X 220.*

FIG. 3. *Chronic glomerulonephritis. Both glomerular hypercellularity and thickening of the glomerular capillary walls have distorted the glomerular tuft. Adhesions are present between the glomerular tuft and capsule. Hematoxylin and eosin. X 220.*

FIG. 4. *Early membranous glomerulonephritis from a 55 year old woman with the nephrotic syndrome. Only minimal changes are visualized by light microscopy of this biopsy. There is some suggestion of increased thickness of the basement membrane of the glomerulus. Hematoxylin and eosin. X 220.*

FIG. 5. *Preeclampsia. Renal biopsy one week following delivery from a 24 year old woman who developed preeclampsia during the seventh month of gestation and underwent a cesarean section. The glomerular capillary lumens are compressed by swollen endothelial cells. Proteinaceous material is present in Bowman's space. Hematoxylin and eosin. X 220.*

FIG. 6. *Preeclampsia. Same biopsy as Fig. 5 but stained for basement membrane. The glomerular basement membrane is thin and discrete (arrow). The capillary lumens are compressed by swollen endothelial cells. Resorcin-fuchsin stain. X 220.*

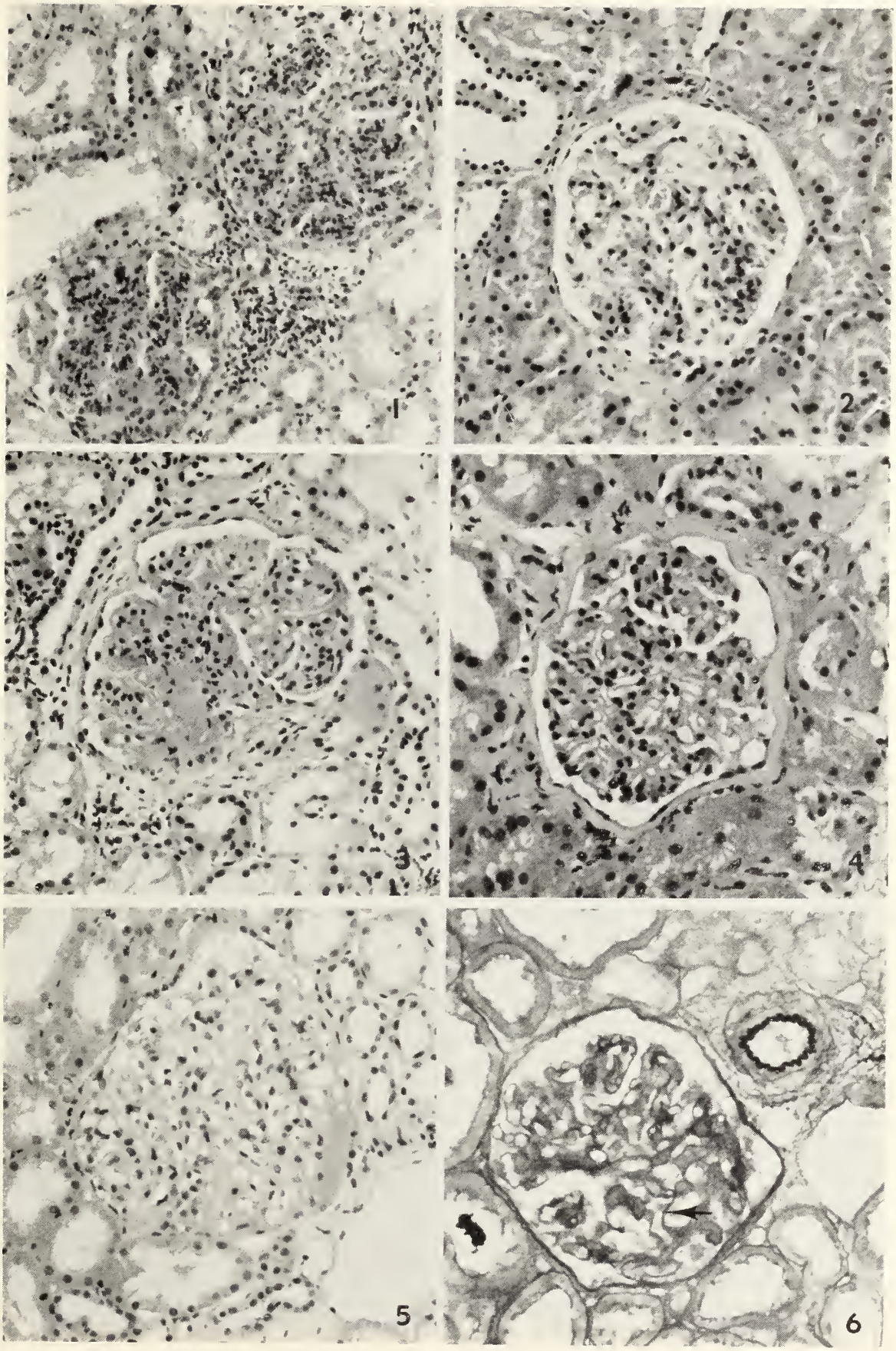


FIG. 1–6. *(See legends on facing page).*

danger of bleeding. However, if warranted, a biopsy can be performed under these circumstances after treatment of the hypertension or following the control of the clotting deficiencies by dialysis or transfusion. The tendency of a pregnant patient in the third trimester to hemorrhage from an engorged kidney is a relative contraindication to renal biopsy.

Although most renal biopsies are not significantly complicated, gross or microscopic hemorrhage into the renal pelvis or into the perirenal tissues occurs commonly following biopsy. Usually the bleeding is readily controlled by bed rest. Rarely, surgical vascular stasis or even nephrectomy may be indicated. The incidence of loss of a kidney following renal biopsy is probably less than one in 1,000 cases. The mortality rate from renal biopsies is still lower.[8, 9, 12] Renal biopsies may leave small residual scars in the kidney, which do not alter renal functions. Because of this scar some authors state that a subsequent follow-up biopsy should be taken from the opposite kidney[21]; however, the same kidney has been used by us for follow-up renal biopsies without difficulty. Suspected renal cysts or neoplasms are, in general, not biopsied because of the complications of hemorrhage or spread of the neoplasm and because of the focal nature of these diseases.

Special Considerations in Obtaining and Processing Renal Biopsies

Before biopsy, the clotting of the candidate should be evaluated to insure against abnormal bleeding tendencies. Roentgenograms should be obtained to estimate the size and to locate the positons of the kidneys. Contrast studies are often helpful to outline the kidneys and to give some indication of renal functions. Typed and crossmatched blood should be available in case of hemorrhage from the kidney at biopsy. Patients should be premedicated to allay apprehension but not to the point that they can no longer cooperate. In our hands, the Franklin modification of the Vim-Silverman needle has been most satisfactory to obtain the biopsy specimen. Some writers[22, 23] have advocated fluoroscopy to locate the kidneys during the biopsy procedure; however, with adequate prebiopsy x-ray localization we have not found this necessary.

One cannot stress too strongly the need for the team approach to renal biopsy. The clinical physician, pathologist, and technician all must work together to provide the most desirable results. Once the tissue has been removed from the patient it must be handled with the utmost care. The core of tissue should be carefully and immediately removed from the needle and placed into a buffered fixative. We use 4 per cent phosphate-buffered formaldehyde at pH 7.4. The tissue is fixed for a period of from 2 to 12 hours before it is embedded in paraffin. Sections are routinely cut at 4 micra and stained with hematoxylin and eosin and by periodic acid-Schiff reaction for basement membranes. Many other stains are available and may be used as indicated.

Careful handling of the specimen by a skilled technician facilitates the histopathologic evaluation by the pathologist. Using these precautions, material adequate for a diagnosis is obtained in over 90 per cent of our biopsies. In general, several glomeruli with their adjacent tubules and blood vessels should be present to consider the biopsy adequate. One must

FIG. 7. *Diabetes mellitus in a 40 year old woman with the nephrotic syndrome. Both nodular and diffuse sclerosis are present within the glomerular tuft. Hematoxylin and eosin. X 220.*

FIG. 8. *Renal cortical necrosis in a 29 year old woman with abruptio placentae. Both the glomeruli (top) and proximal tubules are necrotic. Hematoxylin and eosin. X 170.*

FIG. 9. *Ethylene glycol induced acute proximal tubular necrosis in a man who ingested antifreeze. Note the calcium oxalate crystals (arrow) distorting the proximal tubular cells and obstructing the tubular lumens. Hematoxylin and eosin. X 170.*

FIG. 10. *Regeneration of proximal tubules in a 36 year old man who sustained marked body trauma with hypotension following a motorcycle accident. The biopsy was taken 45 days following the trauma. The patient had acute renal failure with initial oliguria. He was dialyzed and was in the diuretic phase at the time of the biopsy. Note the regenerating cuboidal epithelial lining cells. A focus of calcification (arrow) is present within one tubule. Hematoxylin and eosin. X 170.*

FIG. 11. *Accelerated hypertension in a 43 year old man with progressive hypertension and renal failure. The small artery on the left has an edematous, thickened wall and narrow lumen. The arteriole on the right has fibrin within its wall. Hematoxylin and eosin. X 220.*

FIG. 12. *Electron microscopic photograph of a portion of a renal glomerulus from a patient with a familial hematuric nephritis. The glomerular basement membrane (BM) is thickened. An erythrocyte (E) is present within Bowman's space (B). (C), capillary lumen. Lead citrate and uranyl acetate stained. X 4,700.*

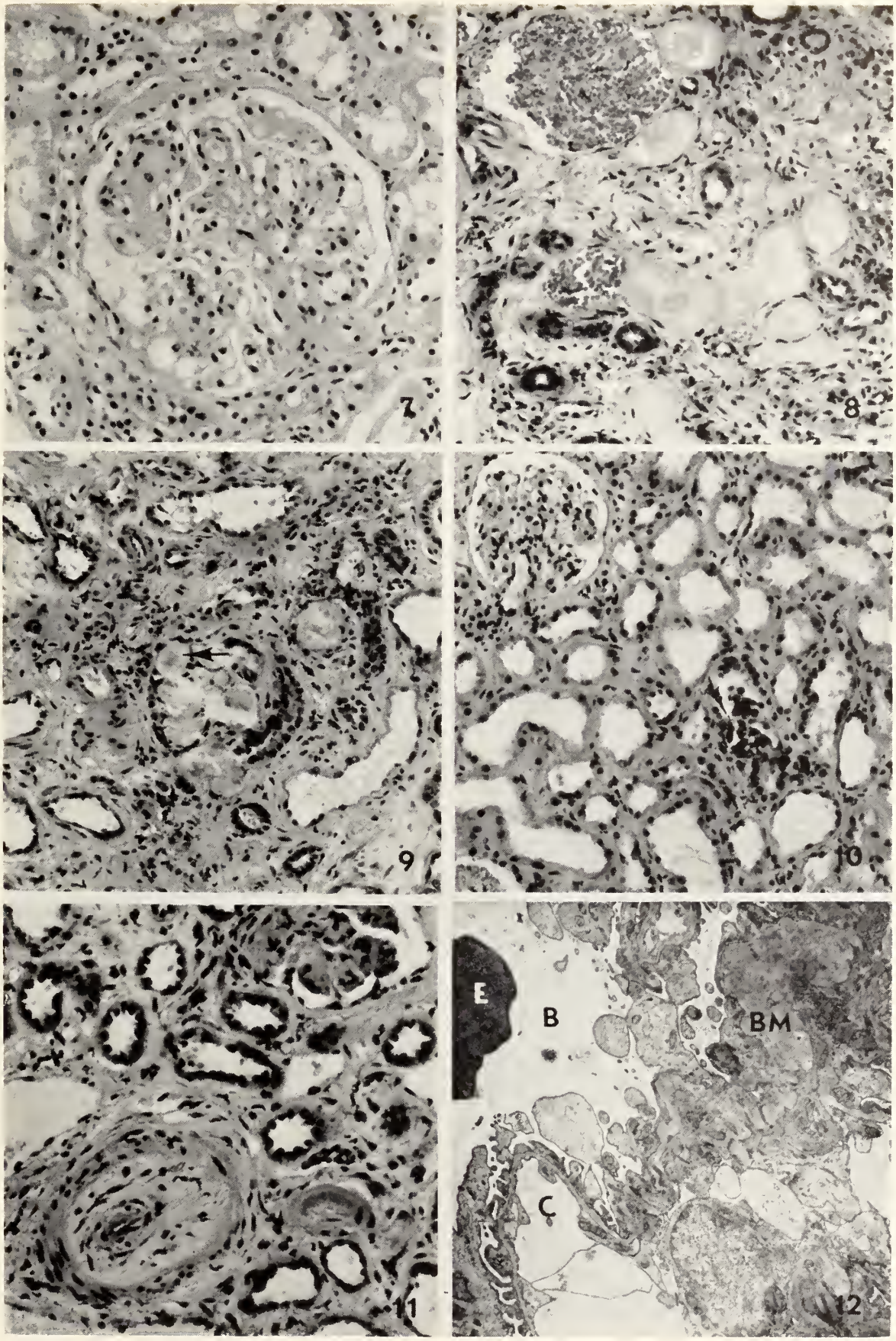


FIG. 7–12. *(See legends on facing page).*

remember that the typical renal biopsy measuring 1.0 to 1.5 cm. in length and 0.2 cm. in diameter is only approximately 1/10,000 of the total renal mass. Sampling errors can be great; therefore, renal biopsies should be interpreted with care and should usually be performed on patients suspected of having diffuse renal disease.

Florescent staining technics are now available to help in the evaluation of hypersensitivity forms of glomerulonephritis.[21-26] Components of sera, such as fibrinogen, gamma globulin, albumin, and complement, are often involved in antigen-antibody complexing diseases and often become localized along the glomerular basement membrane in characteristic patterns. With experience and some skill the pathologist may find these localizations helpful in establishing both the diagnosis and the activity of the disease. Examples of diseases with characteristic fluorescent staining patterns include proliferative and membranous glomerulonephritis, lupus erythematosus, and eclampsia. Diseases such as familial hematuric nephritis, diabetes, and amyloidosis often have a similar appearance by routine light microscopy but do not contain these characteristic fluorescent complexes.

Examination of renal biopsies by electron microscopy has also become helpful in selected cases. The glomeruli in idiopathic nephrotic syndrome[14] or familial hematuric nephritis[15] may appear nearly normal by light microscopy, yet definite alterations are usually visualized by electron microscopy. Preparation of tissues for electron microscopy, however, is time-consuming, involving nearly 50 hours of work for each biopsy, and the sampling error is further magnified. We do not consider the results obtained from electron microscopy to be of sufficient value to warrant its use routinely in renal biopsies. We have reserved the major use for this procedure as a research tool in the investigation of the pathogenesis of disease.

Under certain circumstances enzyme histochemical of biochemical procedures may prove useful. While their use is limited at present, these procedures may play a more important role in the future.

Of additional importance is the attempt on the part of the pathologist to semiquantitate the renal alterations visualized. Careful and complete reports should be submitted by the pathologist and recorded to insure an understanding of the patient's disease at the time of the biopsy and, just as important, for review when subsequent biopsies or evaluations of the patient are performed.

Summary

During the last several years percutaneous needle biopsy of the kidney has become a useful procedure as an aid in establishing the diagnosis of a renal disease, staging the course of the disease and its reversibility, directing therapy, and understanding the pathogenesis of renal diseases. The indications for a renal biopsy, therefore, center around these factors.

Contraindications to renal biopsy include the uncooperative patient, the presence of only one kidney, and the presence of a bleeding disorder. The complications of the procedure in general involve hemorrhage from the biopsy site. A fair percentage of biopsied patients have microscopic hematuria following the biopsy, which can usually be easily controlled by bed rest.

Special ancillary procedures useful in implementing the technic include intravenous pyelography, fluorescent monitoring of the procedure, and electron microscopy, fluorescent microscopy and special stains performed on the biopsy material. The team approach to renal biopsy has been emphasized in the evaluation of the disease of a given patient.

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Post-Emetic Rupture of the Esophagus

Case Report

CHARLES V. MECKSTROTH, M.D., and A. MICHAEL BROENNLE, B.A.

POST-EMETIC rupture of the esophagus is a well defined though rare clinical entity that requires awareness of its characteristics so that early diagnosis can be followed by rapid definitive therapy. Failure to make a prompt diagnosis is life-threatening to the patient since perforation of the esophagus is the most serious and most rapidly fatal perforation of the entire gastrointestinal tract.

Case Report

This 65-year-old white man was relatively well until four o'clock on the afternoon of May 3, 1966. At this time, the patient developed abdominal pain during a beer drinking bout. He vomited two cups of coffee ground material and after 30 minutes he vomited again, noting bright red blood in the vomitus. At this time, he also experienced sharp, retrosternal pain and felt like "something had broken" in his chest. Within an hour, medical attention was obtained and the patient was transferred to another hospital at 5:30 P.M. A chest film was taken at 7:00 P.M. and a diagnosis of pneumothorax was made. The patient was given two units of blood over the next hour, but he failed to respond. He was then transferred to Ohio State University Hospital, arriving at 12:30 A.M.

A review of the patient's history revealed that for many years he has had episodes of upper abdominal pain and had received some treatment for this. He had been a heavy beer and liquor drinker in the past. For the past two weeks, he had complained of "heart burn" of varying severity.

Physical examination showed a patient with a pulse of 160, blood pressure unobtainable, cyanosis, and labored respirations. The neck veins were not distended, the left chest was tympanitic, and the abdomen appeared negative. Chest roentgenogram was obtained (Fig. 1).

A chest tube was immediately inserted and a nasogastric tube was passed. The contents of the left chest proved to be 1,000 cc. of coffee ground material similar to that obtained from the nasogastric tube. A large volume of air was removed from the left chest. The diagnosis of spontaneous rupture of the esophagus was made, and a barium swallow was performed, which showed the barium had flowed through the esophageal tear and into the left pleural space (Fig. 2). The patient was given 1,000 cc. of Ringer's lactate solution, two units of whole blood, and massive doses of antibiotics.

Laboratory data showed a hemoglobin of 14.6 with a white blood cell count of 9,500. The carbon dioxide combining power, sodium, and potassium were within normal limits. The chloride level was 92 mEq./liter. The prothrombin time was 70 per cent and the urinalysis showed 4-plus bacteria with a specific gravity of 1.019.

From the Division of Thoracic Surgery, The Ohio State University Hospitals and The Ohio State University College of Medicine, Columbus, Ohio. Submitted May 2, 1967.

The Authors

● Dr. Meckstroth, Columbus, is Associate Professor of Surgery, Division of Thoracic Surgery, The Ohio State University Hospitals.

● Dr. Broennle, Cleveland, 1967 graduate of The Ohio State University College of Medicine, presently is an Intern at Cleveland Clinic Foundation.

Within four hours from the time of arrival at the emergency room, the patient was on the operating room table and the left chest was opened through the sixth intercostal space. Approximately one quart of gastric contents was found in the chest in spite of the previously placed chest tube. The entire pleura was inflamed and was covered with fibrin and previously ingested barium. The hole in the esophagus was approximately 1½ inches long and

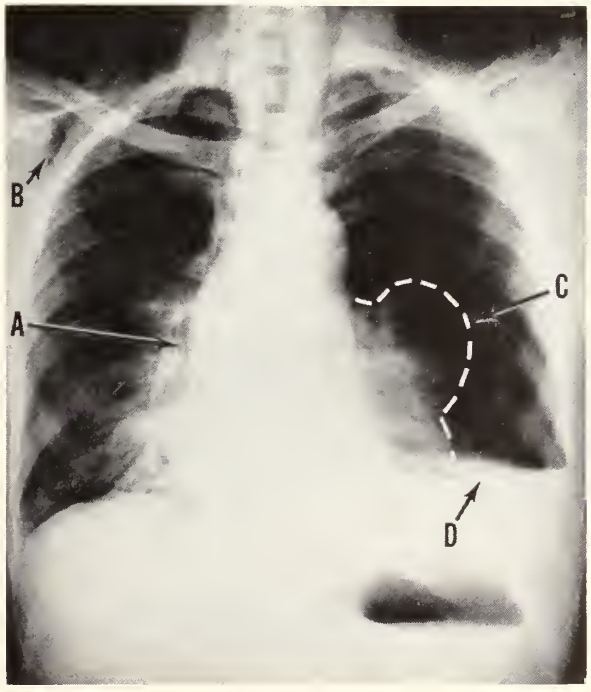


FIG. 1. (a, b, c, d). *Note signs characteristic of ruptured intrathoracic viscus:* (a) *mediastinal emphysema,* (b) *supraclavicular subcutaneous emphysema,* (c) *collapsed lung,* (d) *air-fluid level.*

started 1 inch superior to the diaphragm. With retraction, the muscular layer of the esophagus was found so that the exact extent of the tear could be visualized (Fig. 3). The mucosa was reddened, but showed no obvious ulcerations. The nasogastric tube was guided into the stomach. The tear was closed with a row of interrupted silk sutures inverting the mucosa. A second layer of similar material was used to close the muscular layer. A third layer of closure was performed using diaphragm, adjacent lung tissue and aortic pleura. Two chest tubes were inserted in the pleural space. The first was located 1 inch posterior to the repair and the other was placed anterior to the lung. The chest was washed with Clorpactin® solution and closed in routine fashion.

The patient was then placed supine; a pararectus incision was made and a temporary gastrostomy performed. A Levin tube was placed in the stomach and guided through the pylorus to the superior portion of the duodenum. A No. 22 gastrostomy tube was placed along side this and both tubes were placed on suction. The stomach was tacked against the abdominal wall before closure. A tracheostomy was not performed.

Postoperatively, the patient showed some signs of early delirium tremens. He was treated with intravenous alcohol and sedation. He also developed a temporary skin ulceration from the leakage of gastric contents around the gastrostomy site. He was discharged on May 26, his 22nd hospital day. He has been seen on several occasions as an outpatient and is without symptoms, swallows very well, and is working daily.

Discussion

Boerhaave first described post-emetic rupture of the esophagus in 1724, in a classic treatise describing the death of a gluttonous Dutch sea captain.[1] Collis made the earliest attempt to treat the lesion by closure of the defect in 1944; the patient died the next day.[2] In 1947, the first reports of successful primary closure of the esophageal tear, using a thoracotomy approach, were made by Olsen and Clagett[3]; and Barrett.[4]



FIG. 2. *Ingested barium has passed through the esophageal tear and is shown on the parietal pleura.*

Most cases of this syndrome have been reported as "spontaneous perforation of the esophagus," but the authors prefer the more accurate term "post-emetic rupture" proposed by Samson which refers to the common traumatic etiology.[5] Derbes found it required an average of 15 pounds of pressure to rupture fresh calf esophagi.[6] These tremendous pressures brought on in the living patient by intense abdominal and chest wall muscle contractions can hardly be considered spontaneous. Most of the principles of its diagnosis can be applied to other cases of esophageal rupture or perforation regardless of cause.



FIG. 3. *Artist's conception of the findings at surgery. The barium can be seen overlying the mediastinal pleura. The aorta is retracted to show the ragged tear in the esophagus.*

The patient's history is classically one of vomiting or retching interrupted by severe chest or abdominal pain. Typically, the patient is a middle-aged man with a history of chronic upper gastrointestinal disturbance. A history of alcoholism or poor nutrition may be obtained. Following a large meal or alcoholic indulgence, he has an episode of severe vomiting interrupted by intense pain, either substernal or high in the epigastrium and sometimes accompanied by vivid tearing or bursting sensation in the chest. The pain may radiate to the neck, to the side (left more frequently than right), to the shoulder or abdomen. It is characteristically unrelieved by narcotics. Circulatory collapse and dyspnea follow over a period of several hours. The patient is restless, frequently preferring a sitting position and complaining of extreme thirst.

Crepitus from subcutaneous emphysema is frequently encountered within several hours, beginning suprasternally and progressing to the neck and facial areas. Other physical findings include cyanosis, dyspnea, mediastinal crunch (from mediastinal emphysema), abdominal muscle rigidity, tachycardia, hypotension, fever, and hoarseness.

Roentgenologic findings are: (1) mediastinal emphysema, an early sign, (2) subcutaneous emphysema, (3) hydrothorax and/or pneumothorax, usually involving the left side but rarely bilaterally, and

(4) extravasation of contrast media from the esophageal tear.[7] An iodinated oil or water soluble solution such as Hypaque® can also be used.

Differential diagnosis primarily involves myocardial infarction and perforated peptic ulcer. Other conditions which have been considered are spontaneous pneumothorax, interstitial emphysema, dissecting aortic aneurysm, incarcerated diaphragmatic hernia, pulmonary embolism, acute pancreatitis, acute cholecystitis, mesenteric thrombosis, and poisoning. A sequential history will often rule out abdominal disease. The physical and roentgen findings will generally differentiate ruptured esophagus from other thoracic disease.

Most case descriptions emphasize the relatively normal appearance of the esophagus at the time of early repair. A logical proposal of the sequence of events is: (1) incoordination of the normal mechanism of vomiting, eg, from alcohol, sedation, central nervous system (CNS) disease, (2) sudden release of increased intragastric pressure against a closed cricopharyngeal sphincter or spasm of the esophagus inferior to the cricopharyngeal sphincter resulting in (3) an intraesophageal pressure greater than the tensile strength of the esophageal wall and resulting in rupture.[8] Mackler has shown experimentally that the musculature ruptures first, followed by a mucosal diverticulum-like protrusion, which then ruptures.[9] He studied cadaver esophagi in which the air pressure required to burst the esophagi averaged 5 pounds per square inch. There are three peculiarities of the lower esophageal wall, which are responsible for the location of the rent, usually occurring posterolaterally on the left side in the lower one third: (1) the esophagus tapers in a conical fashion, (2) the circular and longitudinal muscles are thinner than those of the adjacent stomach, and (3) segmental defects in the musculature are found at the site of entrance of vessels and nerves.

The Mallory-Weiss lesion has been suggested as a possible early stage in the evolution of rupture of the esophagus. These linear ulcerations of the mucous membranes longitudinally arranged around the cardia involving both esophageal and gastric mucosa are postulated as representing incomplete ruptures, and, with subsequent abscess formation, may rupture through the remaining wall.[10] The most common symptom described in patients with Mallory-Weiss lesions is massive hematemesis. While patients with post-emetic rupture of the esophagus frequently have some hematemesis, it usually follows the onset of their pain and is small in quantity.

The physical findings after rupture depend on its extent. If the mediastinal pleura over the rent is still intact, subcutaneous emphysema at the base of the neck occurs early and represents esophageal air ascending in the mediastinum. If the pleural space has been entered at the time of perforation, almost total collapse of the lung will quickly ensue unless the space has been completely obliterated by previous adhesions. In either case, the caustic action of gastric juice on mediastinal contents or pleural space produces a state of shock with its characetristic findings. Massive bacterial suppuration quickly follows.

Treatment requires immediate thoracotomy with closure of the defect following resuscitative measures including oxygen and aggressive fluid and blood administration. A Levin tube should be inserted to prevent further contamination by gastric secretions. A tube thoracotomy for massive pneumothorax may facilitate induction of anesthesia. Antibiotic therapy is begun. Blood is given as soon as it is available. Care must be taken not to delay thoracotomy too long with preoperative endeavors.

Through a posterolateral thoracotomy, all pleural space contents are evacuated. The mediastinum is widely opened. This decompression often results in dramatic improvement in the patient's cardiorespiratory status, a point to be remembered when the response to resuscitative efforts is not satisfactory. Following mediastinal debridement, the rent is located and the esophagus is inspected for other tears or disease. The nasogastric tube is advanced well into the stomach. The defect is closed longitudinally with nonabsorbable sutures. The mediastinal pleura, superior to the defect, is kept open but that over the rent is closed to give additional support to the repair. The area is irrigated well and the pleural space is drained with two chest tubes, one being placed close to the repair and kept in place with a catgut suture. A gastrostomy is performed as a double precaution against acute gastric dilatation or the corrosive action of gastric juice on the suture line. Decompression for 24 to 28 hours may be followed by liquids given through the gastrostomy tube. Barium studies of the anastomosis may be done before permitting oral intake.

Immediate postoperative mortality is principally due to continued shock and cardiorespiratory failure. Deaths one to two weeks postoperatively are usually from infection. In those patients where the diagnosis is not made until after infection is established, benefit may be obtained from a drainage procedure. Increased morbidity, however, is found in patients so treated. Of 30 cases reviewed by Samson, 15 patients had primary closure within 15 hours of rupture, and of these, 10 survived with convalescences of 13 to 22 days. Fifteen patients were treated by drainage with eight survivals and periods of convalescence from six weeks to 1½ years.[5] Postlethwait and Sealy compiled the results of surgical intervention in 117 patients with esophageal perforation of the "spontaneous" type. Thoracotomy with closure was done in 71 patients with 49 or 69 per cent recovering. Of 46 treated with other procedures, usually drainage of the empyema, only 21 or 45.6 per cent recovered.[8]

Summary

A case of post-emetic rupture of the esophagus is presented. The clinical picture and pathophysiology are discussed. Awareness of its occurrence is the prime requirement for rapid diagnosis. Prompt thoracotomy with primary closure of the defect is the treatment of choice.

Iatrogenic perforations of the esophagus by small (8-14 French) dilators are entirely different situations. These can frequently be treated conservatively with esophageal (and if possible gastric) suction, antibiotics, and intravenous fluids. The post-emetic perforations are generally an inch or so long and require immediate thoracotomy with suturing.

Since a delay in closure of 24 hours usually results in the death of the patient, physicians should maintain a high index of suspicion in all patients whose complaints variously suggest perforated peptic ulcer, myocardial infarction, and dissecting aortic aneurysm.

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PERFORATION OF THE ESOPHAGUS most commonly occurs as a result of instrumentation by the endoscopist. The cervical esophagus is the most common site of perforation. Prompt surgical drainage through the neck will avoid the spread of mediastinal infection and end in an excellent result in almost all instances.

If a perforation occurs in the lower thoracic esophagus at the site of an esophageal tumor or stricture and the diagnosis is made early, an operative procedure may be carried out immediately for resection of the tumor or stricture and an esophagogastrostomy performed. In the five instances in which this procedure has been carried out, infection did not constitute a problem in any of the patients. In an additional patient, this procedure was used successfully at 12 hours following perforation after the attempted removal of impacted meat from the lower esophagus.

If perforation of the esophagus by means of the esophagoscope or spontaneous perforation is seen by the surgeon as a late complication, adequate drainage along with appropriate measures to sacrifice the esophagus in order to avoid continued contamination of the mediastinum appears to be the most effective method of salvaging these patients. The esophagus may then be replaced by a segment of the colon at a later date. — Julian Johnson, M. D., and Cletus W. Schwegman, M. D., Philadelphia: *American Journal of Gastroenterology,* 47:365-372, May, 1967.

Spontaneous Perforation of the Colon

Report of Two Cases in a Family Exhibiting Marfan Stigmata

JOHN M. COOK, M.D.

IN THE family to be described there was a total of three spontaneous perforations of the sigmoid colon occurring in two individuals. There were also two instances of Marfan's diathesis and perhaps many more. It is the purpose of this paper to present an unusual coincidence rather than to prove any casual relationship between the two conditions named.

Spontaneous Perforation of the Colon

Case 1: This 22 year old white unmarried women died February 21, 1963 of peritonitis. At the age of 8 years an operation was performed for perforation of the colon. She made a stormy recovery. On December 3, 1962, she was operated upon because of pain and a palpable mass in the left lower quadrant of the abdomen. A large lutein cyst over 5 cm. in diameter was removed. There were extensive scarring and malposition of the sigmoid colon but no perforation.

A nodule of the left breast was excised February 19, 1963. The pathologist's report was myxomatous adenofibroma of the breast. She was discharged from the Oak Hill Hospital on February 20, 1963.

The following day she was readmitted because of sudden severe abdominal pain. Blood pressure was 60/0; pulse rate was 140 per minute. At surgery the peritoneum was found to be full of cloudy fluid and "turnip greens." The perforation of the sigmoid colon was 3 mm. in diameter and was sutured. Postoperatively, the patient again developed severe shock and she died 36 hours after admission.

Autopsy revealed that the repair of the perforation was intact but that there was widespread peritonitis. No diverticula of the colon were found.

Case 2: This was the eldest sister of Case 1. In 1948 this 24 year old woman was admitted to a hospital in Dayton, Ohio. She was not operated on and died in 30 hours. Autopsy revealed perforation of a diverticulum of the sigmoid colon with generalized peritonitis. No other diverticula were described.

Marfan's Syndrome

Case 3: The nephew of the patients in Cases 1 and 2, was treated at the age of 8 years at Children's Hospital in Columbus. He had ocular, skeletal, and cardiovascular stigmata of Marfan's snydrome. He had a history of subluxation of the lenses of the eyes. Examination revealed dolichocephaly, high arched palate, long fingers and toes, and systolic murmur heard at the apex. He was an aesthenic individual with diminished subcutaneous fat. Joints were hyperextensible and there was bilateral pes planus.

Case 4: The father of the boy above and the brother of patients in Cases 1 and 2, had most of the skeletal characteristcs of arachnodactyly.

Case 5: The father of patients 1 and 2, had been described as a tall slender man with long fingers and arms resembling Case 4, and photographs have confirmed this description. He had joint pains for 18 years before he died suddenly at the age of 48. He may have had some rheumatic disease. He probably had Marfan's syndrome. Four of his sisters died suddenly in their 40's of what was reported as "heart attack." His nephew may have had Marfan's diathesis.

Submitted May 2, 1967.

The Author

● Dr. Cook, Oak Hill, Ohio, is Surgeon at Oak Hill Hospital.

Discussion

Marfan's syndrome, also called arachnodactyly, is a heritable disorder of connective tissue characterized by widespread malformations affecting musculoskeletal, cardiovascular, and ocular systems. All systems need not be involved in one individual.[1]

The only frequently mentioned gastrointestinal disorder related to arachnodactyly is hernia.[2]

The only cutaneous alteration associated with arachnodactyly is the occasional appearance of thin translucent skin with diminished subcutaneous fat.[1]

It has been suggested that congenital abnormalities of the kidneys may occur in conjunction with Marfan's syndrome.[3]

To my knowledge there never has been a description of connective tissue defect of the colon in the presence of arachnodactyly. The assumption must be made that arachnodactyly had no causal relationship with spontaneous perforation of the colon, since the two conditions did not occur in the same individual.

Summary

In a family with Marfan's stigmata, two individuals had a total of three spontaneous perforations of the sigmoid colon. These two patients had no known manifestations of arachnodactyly. In this family there is no evidence of causal relationship between Marfan's syndrome and spontaneous perforation of the colon.

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Heart Page

Peripheral Vascular Disease

II. Differential Diagnosis of Chronic Occlusive Arterial Disease

RAY W. GIFFORD, JR., M.D.

FREQUENTLY it is easier to establish the diagnosis of chronic occlusive arterial disease than it is to ascertain its cause.

Arterial trauma and sudden embolic or thrombotic occlusion cause signs and symptoms of chronic ischemia if the limb survives the acute episode and revascularization has not been accomplished surgically. The history of sudden onset of symptoms is helpful in arriving at the correct diagnosis.

Nonspecific arteritis (Takayasu's disease) is rare in this country. It characteristically involves the subclavian and/or carotid arteries, of young women, and consequently the initial symptoms usually relate to ischemia of the upper extremities and/or cerebrovascular insufficiency. When the abdominal aorta is affected, intermittent claudication of the lower extremities results and, rarely, this is the first symptom.

In the great majority of cases, the differential diagnosis is between atherosclerosis obliterans (ASO) and thromboangiitis obliterans (TAO) or Buerger's disease. Despite claims to the contrary, there is abundant evidence that TAO is a distinct entity, roentgenographically, histopathologically, clinically, and prognostically.

When symptoms of chronic occlusive arterial disease first appear after the age of 45 years, the diagnosis is almost certainly ASO; whereas when symptoms of ischemia first appear before the age of 35 years, the diagnosis is almost always TAO. Therefore, it is in patients between the ages of 35 and 45 years that the greatest difficulty in differential diagnosis is encountered. In either diagnostic category, more than 95 per cent of patients in this age range are men, and hence the factor of sex is not helpful.

When arteriosclerosis obliterans begins before the age of 45 years in nondiabetic patients, the occlusive lesions are usually in the terminal aorta and/or the iliac or common femoral arteries, and consequently the first symptom is intermittent claudication in the buttock, thigh, or calf. The initial lesions of TAO, in contrast, are usually in the tibial arteries; therefore, in this disease, intermittent claudication is first noted in the muscles of the arch of the foot.

Ischemic lesions of the fingers favor the diagnosis of TAO, since ASO rarely, if ever, produces symptomatic ischemia of the upper extremities, even though absence of pulsation in the radial or ulnar artery or both arteries is not unusual as a result of atherosclerotic obstruction. Ischemic ulcers of the fingers may be associated with Raynaud's disease, scleroderma, or systemic lupus erythematosus, but these conditions usually occur in women and do not cause intermittent claudication, while TAO usually occurs in men and almost always involves the lower extremities.

Recurrent superficial thrombophlebitis, usually affecting the small veins of the feet, occurs in 40 per cent of patients with TAO, but never occurs in association with ASO.

Evidence of arterial calcification on plain roentgenograms, hypercholesteremia and/or hypertriglyceridemia and diabetes mellitus favor the diagnosis of ASO. Because TAO is usually confined to arteries of the extremities, symptomatic cerebrovascular and coronary insufficiency are more likely to be associated with ASO than with TAO.

Showers of minute cholesterol emboli from an atherosclerotic aorta can produce ischemic lesions in the feet, including livedo reticularis, purpura, localized cyanosis and coolness of digits, and ischemic ulcerations. Major arterial pulsations are normal, so the clinician may erroneously conclude that the patient has TAO confined to the small arteries of the foot. The clue to correct diagnosis is evidence of severe atherosclerotic disease of the abdominal aorta, including evidence of calcification on plain roentgenograms, systolic bruit over the aorta, and, frequently, aneurysmal dilatation of the aorta. Aortography demonstrates extensive intimal disease, and is indicated in this situation.

Except for the fact that surgical revascularization is seldom feasible for patients with TAO, the principles of management of TAO and ASO are similar, but the differential diagnosis is important from a prognostic standpoint. Follow-up studies have shown that major amputations are necessary more often for TAO than for ASO. Patients with ASO have a compromised life expectancy because of atherosclerotic complications in the brain and heart, but patients with TAO have a normal life expectancy.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio.

Electrocardiographic-Pathologic Conference

Myocardosis with Combined Ventricular Hypertrophy

RALPH C. SCOTT, M.D.*

THE FORMAT of the electrocardiographic-pathologic conference (EPC) has been outlined in the first article in this series.[1]

Electrocardiographic Interpretation (Fig. 1)

The QRS duration measures 0.10 sec. There is distinct notching of the upstroke of the R waves in leads I and V_6. The R wave is bifid in lead II and in aVF. No Q waves are present in leads I or V_6. The onset of the intrinsicoid deflection in V_6 measures 0.06 sec. The absent Q waves in leads I and V_6, the late onset of the intrinsicoid deflection in V_6, together with the distinct notching of the upstroke in leads V_1 and V_6, are consistent with the diagnosis of incomplete left bundle branch block. Voltage criteria are also present for the diagnosis of left ventricular hypertrophy. Paroxysmal atrial tachycardia with 2:1 block is present. Although this arrhythmia may not be clearly evident in the reproduction, in a longer strip of V_1 recorded in this patient it was clearly identifiable. This is probably secondary to digitalis intoxication.

Electrocardiographic Summary:

(1) Incomplete left bundle branch block
(2) Left ventricular hypertrophy
(3) Paroxysmal atrial tachycardia with 2:1 block

Clinical Resumé

This 59 year old Negro woman was referred to the Receiving Ward of the Cincinnati General Hospital on April 3, 1966 by her private physician with the diagnoses of rheumatic heart disease, congestive heart failure, and diabetes mellitus. Her symptoms of congestive failure had been reasonably well controlled on digitoxin 0.1 mg. daily until eight weeks prior to admission when dyspnea and edema became progressively worse. On the day of admission nausea and vomiting appeared. In the hospital it was learned that the patient had known heart "trouble" for 33 years, occurring at the age of 26. Physical examination disclosed cardiomegaly with the murmurs of aortic, mitral, and tricuspid insufficiency, elevated venous pressure, and massive peripheral edema.

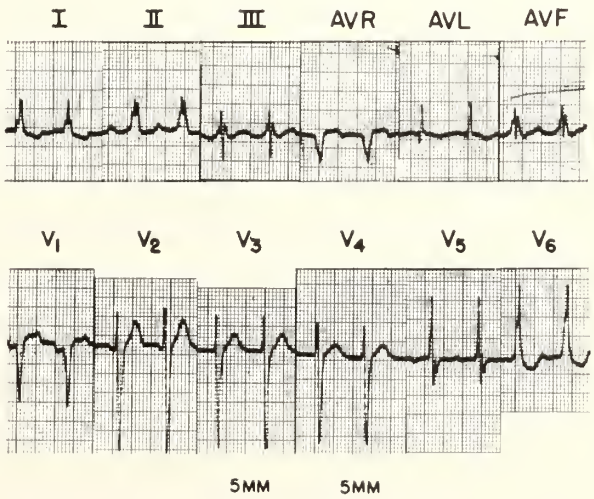


FIG. 1. *The electrocardiogram recorded on 4/4/66 displays incomplete left bundle branch block and left ventricular hypertrophy. Paroxysmal atrial tachycardia with 2:1 block can be identified in lead V_1.*

Her course in the hospital was characterized by recurrent arrhythmias, persistent metabolic acidosis, oliguria, and severe heart failure. She died on April 4, 1966.

Necropsy Findings

At autopsy this 59 year old woman was of average build, weighing 130 lbs., and measuring 66 inches in length. The cause of death was cardiac failure.

The pericardial sac contained 600 cc. of clear yellow fluid but was not tense. The heart was massively enlarged, weighing 930 grams. After removal of the epicardial soft tissues it weighed 870 Gm. The weight of the left ventricle plus septum (LV+S) was 530 Gm., which is enormously increased above the upper limit of normal of 175 Gm. The right ventricular free wall (RV) weighed 192 Gm. which is

From the Cardiac Laboratory, Cincinnati General Hospital and the Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. Submitted November 1, 1967.

Supported by Public Health Service Research Grant HE-08578. Additional support was received from the Heart Association of Southwestern Ohio, Inc.

*Dr. Scott, Cincinnati, is Associate Professor of Medicine, University of Cincinnati College of Medicine, and Director of Cardiac Clinics, Cincinnati General Hospital.

also considerably increased above the upper limit of normal of 65 Gm. Both atria were enlarged, the left atrium weighing 44 Gm., the right 40 Gm., and the interatrial septum 12 Gm. All four chambers were markedly hypertrophied and dilated. A mild degree of diffuse endocardial sclerosis affected the lower half of the left ventricle, but there was no evidence of mural thrombosis. All valve rings, particularly the tricuspid, pulmonic and mitral valves were markedly dilated, but there was no intrinsic valvular disease. The coronary arteries were minimally sclerotic.

The myocardium was normal on gross inspection. Microscopic examination showed marked hypertrophy of individual fibers with moderate, irregularly distributed interstitial fibrosis and occasional foci of myocytolysis.

Anatomic Diagnoses:

(1) Myocardosis (primary myocardial disease)
(2) Combined ventricular hypertrophy, marked
(3) Interstitial fibrosis, moderate

Comments

This is an example of primary myocardial disease with rather marked cardiac enlargement. There was enormous hypertrophy of the left ventricle, and to a somewhat lesser degree, of the right ventricle. There was also hypertrophy of both atria and there was generalized cardiac dilatation.

The electrocardiogram displayed incomplete left bundle branch block and in the precordial leads voltage criteria were present for the diagnosis of left ventricular hypertrophy. In the author's opinion, contrasting with the situation in complete left bundle branch block,[3] in the presence of incomplete left bundle branch block, the voltage criteria for the diagnosis of left ventricular hypertrophy are usually valid. The diagnosis of associated right ventricular hypertrophy was not made in the present electrocardiogram. This may be compared with the tracing illustrated in the last Electrocardiographic-Pathologic Conference[2] in which it was possible to diagnose biventricular hypertrophy. In retrospect, perhaps more attention should have been placed on the comparatively shallow S waves in V_1 in the present tracing in contrast to the deeper S waves in V_2 through V_4.

In the presence of the paroxysmal atrial tachycardia it was not possible to diagnose atrial enlargement.

Acknowledgments: The author wishes to express his thanks to Dr. Kevin E. Bove, who performed the detailed necropsy examination in this case, and to Dr. Robert J. Norris and Dr. Emmett Conyers for their participation in the electrocardiographic and clinical correlation.

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RETROPERITONEAL FIBROSIS may be a self-limiting condition, and spontaneous remission has been recorded. But in some cases it is progressive and fatal. Recognition is all the more important because, once the condition is thought of, diagnosis in the average case is not difficult and treatment is often rewarding. Hypertension with a history of abdominal pain, a raised blood urea and erythrocyte sedimentation rate, and abnormalities in the plasma proteins, especially if there are other seemingly bizarre clinical features, should suggest the need for pyelography, especially by the retrograde route. The features are characteristic: delayed excretion of dye, with hydronephrosis and hydroureter above an obstruction, which is commonly in the midlumbar region or at the pelvic brim, and medial deviation and irregularity of the ureter at the site of obstruction. In difficult cases lymphangiography may also be valuable. Operation to free the ureters is often strikingly successful, though further obstruction may occur, and in some patients an affected segment of ureter has had to be resected. — *British Medical Journal*, 4:5, Oct. 7, 1967.

Special Article

The Alcoholic in Industry

C. F. WILCOX*

With introduction by WILLIAM W. DAVIS, M. D.†

IT HAS BEEN adequately demonstrated that the establishment of a company recognized plan for dealing with the disease of alcoholism is of great benefit to employer and employee. The company that feels this is a moral problem and will terminate the employee when the effect of his alcoholism becomes apparent in his work is only penalizing itself. This company's policy might be summarized as, "Our company will pay a premium to its employees for the successful concealment of alcoholism. When it can no longer be concealed, the employee will be terminated."

North American Rockwell Corporation is very proud of the fact that there has been a counseling program in operation for assisting alcoholics for more than 20 years. Experience at North American's Columbus Division with employee counseling and medical guidance has been rewarding. Many skilled employees have been saved from deterioration and made productive again. It is well established that in the United States of America 6 per cent of the working force is alcoholic.

The following guide prepared by our alcoholic counselor has proven very practical in giving a supervisor the encouragement to get started with his employee who needs help.

What Do You Say To An Alcoholic Employee?

When a man's drinking begins to interfere with his job, his immediate supervisor is expected to deal with the problem. But how? We've been asked what he should do; what he should say. Here are some specific answers from a recovered alcoholic who has been successful in helping alcoholics help themselves.

The business world now accepts four facts about alcoholism and the alcoholic:

1. Alcoholism is an illness; not a moral problem.
2. Alcoholism can be treated.
3. The alcoholic is worth treating.
4. The alcoholic is the last to recognize or to accept his problem.

This article deals solely with the approach a supervisor may take to give the alcoholic an opportunity to admit, accept, and attack his illness, so that he can remain employed. The alcoholic must be convinced that he will not only become unemployed, but unemployable.

There is a fine distinction between the heavy drinker who doesn't allow his drinking to interfere with his job, and the probable alcoholic who gives continuous evidence of never allowing his job activities to interfere with his drinking.

There is never a "right" time to discuss excessive drinking with an alcoholic employee. If he is sober, one hesitates to remind him of past distress. If he has a hangover or is drunk, his reactions are not responsible and discussion will be futile.

No Longer a Private Matter

Confronted with the prospect of the drinker's resentment, defiance, or excuses, the supervisor usually falls back on the hope that a small reprimand for lateness or hangover or carelessness will lead the drinker to mend his ways. But alcoholism is not that easily licked. It is a progressive disease that, without concerted effort, never gets better—only worse.

If you have an employee working for you whom you suspect of having a drinking problem, you may say to yourself, "Do I have the right to invade this man's privacy?" A little thought should make you realize that his drinking, on or off the job, is no longer a private matter if it interferes with his job performance. His job, your job, and the morale of the rest of the employees are affected. Like it or not, it is your responsibility as a supervisor to take action.

What To Do About It

North American Rockwell for many years recognized alcoholism as an illness. For that reason, treatment is available through the Company Medical Section. Assisting the professional medical personnel in this work is a full-time Counselor, who is a recovered alcoholic with years of experience in helping alcoholics to achieve sobriety and respectability.

*Mr. Wilcox is Employee Counselor at the Columbus Division of North American Rockwell Corporation, Columbus, Ohio.
†Dr. Davis, Columbus, is Medical Director, North American Rockwell Corporation, Columbus Division.

Like unused medicine, however, this program cannot assist employees it cannot reach. It is your responsibility as a supervisor to bring the matter to the point where the employee accepts the inevitability of the rehabilitation program or termination.

Resign yourself to the fact that no matter what you say or how you do it, the interview with the employee will be unpleasant. You should expect denials, excuses, rage, remorse, lies, and promises. Do not allow yourself to be put off or diverted.

What Not To Say

Let's consider what you shouldn't say. Don't apologize for bringing up the problem. Never get involved in a discussion of a man's "right" to drink. Alcoholism is not a moral problem—it is an illness.

Don't urge him to be "moderate." Comments like, "Aren't you drinking too much?" or "Why don't you stick to beer?" or "Why don't you save your drinking for week ends?" are useless. He knows he has progressive trouble with drinking, that no amount of slowing down or tapering off will cure. He's already tried these measures and they don't work.

The "scare" technique is equally futile. Don't tell an alcoholic that he'll die of liver trouble if he doesn't lay off the bottle. He's already heard of someone who drank a quart a day and lived to be a hundred.

What To Say

Your main problem in talking to him will be to answer—ideally, before he even voices them—all the excuses and tricks he will use to avoid facing the issue. What is the real issue? Simply this: his drinking —and nothing else—is causing problems in your operation. Not his troubles with his wife or his ungrateful children or his bad back or his money problem. It's his drinking that is responsible for his carelessness, poor attendance record, poor work performance, and the demoralization of the people who work around him. You cannot afford to let this go on. With this approach, you pinpoint the corner into which he has painted himself and force him to realize that he must do something about his drinking to keep his job.

You might start out this way: "Your drinking has developed to the point that your performance is far below your potential. The breath-a-lators you use do not hide your bloodshot eyes or cover your shaky hands. Your attendance record is intolerable and even when you're here you spend more time away from your job than you do at it. Your work performance with respect to both quality and quantity is unsatisfactory. I want you to know that your job is at stake unless you can show me that you're willing to do something about your drinking problem. By this I mean participation in a program that can help you. I suggest you get help immediately or find employment elsewhere."

Record Speaks for Itself

The record shows that approximately 50 per cent of the people contacted, who take advantage of the help offered them, never take another drink. About 25 per cent have one or more slips before they realize that they are alcoholic, and each drunk is worse than the last one. Then they too are rehabilitated. Only 25 per cent are never reached.

With odds like this, isn't it worth a try?

THE MOST IMPORTANT RISK FACTORS found in the Framingham Heart Study during the past 12 years were age, cigarette smoking, cholesterol and blood pressure levels, with men showing less ability than women to withstand the hazardous patterns of living which contribute to these abnormalties.

On the average, a man can be regarded as 15 years older than his chronological age from the point of view of coronary heart-disease risk if:

- He smokes more than a pack of cigarettes daily; or
- His blood cholesterol is elevated by 100 mg./100 ml.; or
- His systolic blood pressure is 60 mm. above normal.

While overweight was also a significant item among the age-adjusted risk factors in the study, its effect was smaller than these others. — U.S. Dept. of Health, Education, and Welfare, PHS, NEWS RELEASE (HEW-S11) Oct. 4, 1967.



NEWS AND Organization Section

Report on AMA Houston Meeting...

Summary of Matters Considered by AMA House of Delegates; Actions Taken, Especially in Regard to Ohio Resolutions

OHIO RESOLUTIONS calling for a review of voluntary health insurance objectives, corrections in Title XIX (Medicaid), acceleration of medical education during the present war emergency, a presidential commission of physicians and medically oriented persons to study deployment of physicians and other health personnel in the armed forces and all government agencies received favorable action in the American Medical Association House of Delegates at the 1967 Clinical Convention in Houston, Texas, November 26-29.

Ohio's resolution on voluntary health insurance, calling for a review of mission, scope, locale, was referred to the Council on Medical Service for study and coordination with other similar projects.

A reference committee substitute for the OSMA resolution calling for support of and changes in Title XIX failed to recognize the difference between direct billing and direct payment. The House accepted an Ohio floor amendment instructing the AMA to press for implementation of Title XIX in a manner which recognizes the physician's right to bill directly all patients, including Title XIX patients, and **for the physician or the patient to be fully reimbursed in the amount of the physician's usual, customary, and reasonable fee for his professional services.**

OSMA's concern over the increasing and disproportionate number of physicians in federal services prompted the resolution calling for the President of the United States to appoint a federal manpower commission to study the use of physicians and other health personnel in federal services of all types, with full recognition of both federal and civilian population needs.

The resolution calling for an acceleration program in medical education such as was used in World War II, the purpose being to help meet the increased demand for physicians in Vietnam as well as the increasing civilian demand, was referred for information to the AMA Board of Trustee's Commission on Health Manpower and to the AMA Council on Medical Education.

The House rejected an Ohio resolution calling for the Clinical Convention to start the second Sunday after Thanksgiving in lieu of the present custom of starting on the first Sunday after Thanksgiving..

Blue Shield Move Opposed

The Ohio delegation strongly supported a successful Iowa resolution calling for the National Association of Blue Shield Plans to reconsider a recent change in NABSP membership requirement from the regulation that required state or county medical society approval to one that accepted, as an alternative, a participating agreement by a majority of physicians in the area.

One of the most contested reports to the House was referred back to the AMA council that wrote the report. A Council on Medical Service report recommending that state and local societies directly accept federal funds to administer government medical care programs was referred back to the Council by the House.

Debate Is Heated

Reference committee hearings produced heated debate, overwhelmingly in opposition to the recommendation. Delegates pointed out that federal funds mean federal control, that "he who pays the

piper calls the tune," and, more colorfully, "When did we decide that we were prostitutes?"

The Ohio delegation, led by Chairman John H. Budd, M. D., of Cleveland, were active participants in the proceedings. Other OSMA delegates seated were Drs. Edwin H. Artman, Chillicothe; Carl A. Lincke, Carrollton; T. L. Light, Dayton; Richard L. Meiling, Columbus; Frederick P. Osgood, Toledo; George W. Petznick, Cleveland; Charles A. Sebastian, Cincinnati, and Robert E. Tschantz, Canton. Dr. E. K. Yantes, Wilmington, was unable to attend and Dr. Harry K. Hines, Cincinnati, an alternate delegate, was seated in his place.

Alternate delegates attending, in addition to Dr. Hines, were Drs. Kenneth D. Arn, Dayton; Henry A. Crawford, Cleveland; Philip B. Hardymon, Columbus; J. Robert Hudson, Cincinnati; Robert S. Martin, Zanesville; H. T. Pease, Wadsworth; Frank F. A. Rawling, Toledo; P. John Robechek, Cleveland, and Robert N. Smith, Toledo. Dr. Rawling was seated as a delegate in the final session to replace Dr. Meiling, who was unable to be present.

Dr. Artman and Dr. Hudson were recognized by the House, commemorating their final session as a delegate and alternate, respectively.

OSMA President Robert E. Howard, M. D., Cincinnati, and Immediate Past President Lawrence C. Meredith, M. D., Elyria, also were active participants in the reference committee hearings and deliberations by the Ohio delegation.

Dr. Light and Dr. Lincke served on reference committees and Dr. Meiling was to have served as a reference committee chairman, but had to decline because he was not able to be present for the entire meeting.

Resume of Other Actions

Among other actions, the House:

- Commended the AMA Board of Trustees for continuing efforts to obtain implementation, with the Joint Commission on Accreditation of Hospitals, of the AMA policy, resulting from an Ohio resolution at the 1967 Annual Convention, calling for physicians to be appointed or elected from hospital medical staffs to serve as full members of hospital boards of trustees.

- Called for hospitals and medical staffs to provide in staff constitutions and bylaws due process in staff appointments, hearings, and appointments, and asked that such be an accreditation requirement.

- Called for AMA and JCAH to seek a means of simplying medical staff attendance requirements.

- Asked for revision of JCAH ruling that externs may not be used in non-university affiliated hospitals.

- Reaffirmed policy that procurement, processing, distribution and use of human blood and other human tissues is a medical service and not sale of a commodity, and called for federal and state legislation to that effect.

- Endorsed a recommendation of the Board of Trustees, presented to the House by AMA Past President Charles L. Hudson, M. D., Cleveland, that the AMA Biomedical Research institute be relocated from the AMA building to the University of Chicago.

- Approved the concept of giving the AMA vice president a vote on the Board of Trustees. Ohio was particularly interested in this action, which resulted from an Indiana resolution, since Ohio will nominate Dr. Lincke for that office at the 1968 Annual Convention in San Francisco.

- Emphasized that health care standards should be set at the local level, and not at the national level.

- Committed the AMA to leadership in informing the profession, government, and the public regarding health care costs, health manpower and related matters.

- Urged state and local medical societies to take leadership in comprehensive health planning and to emphasize variable activities and planning.

- Identified alcoholism as a complex disease, with medicine responsible for its medical components.

- Reaffirmed its support of direct billing under medicare.

- Opposed national drug formulary legislation.

- Reaffirmed support of the American Medical Political Action Committee.

- Called for more effective liaison between medical societies and hospital medical staffs.

- Received AMA-developed model articles of incorporation for hospital medical staffs.

Reprints of Fat Control Diet Articles Are Available

In answer to many requests the Ohio State Heart Association has prepared bound copies of the series, "A Baedeker for Fat-Controlled Diets," which appeared in *The Ohio State Medical Journal.* A limited supply of the reprints are available, without charge, from the Ohio State Heart Association, 10 East Town Street, Columbus, Ohio 43215.

The series which appeared on the "Heart Page," a regular feature of *The Journal,* is a project of the Professional Education Committee of the Ohio State Heart Association.

The House of Delegates Further Delineates the Purposes and Responsibilities of AMA

For more than a century, the constitutionally stated purpose of the American Medical Association has been: "To promote the science and art of medicine and the betterment of public health."

The AMA House of Delegates, at the 1967 Clinical Convention in Houston, adopted, in further delineation of that concept, the following official statement:

The Purposes and Responsibilities of the American Medical Association

It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people.

Its continuing purposes are to meet this responsibility through the following means:

1. By encouraging the further development of medical knowledge, skills, techniques, and drugs; and by maintaining the highest standards of practice and health care.

2. By creating incentives to attract increasing numbers of capable people into medicine and the other health-care professions.

3. By advancing and expanding the education of physicians and other groups in the health-care field.

4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

6. By developing techniques and practices that will moderate the costs of good medical and health care.

7. By seeking out and fostering means of making all health-care facilities — physicians' offices, hospitals, laboratories, clinics and others — as efficient and economical as good medical practice and attention to human values will permit.

8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

9. By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.

11. By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

Deadline for Submission of Resolutions to Columbus Office of the Association Is March 14

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1968 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal,* must be introduced at the first session of the House of Delegates, Monday evening, May 13, at the Netherland-Hilton Hotel, Cincinnati.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 14. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

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et's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



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Each tablet and each 5 cc. of liquid contains:
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in children with . . . Gastroenteritis ▪ Spastic bowel
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Lomotil helps get children with diarrhea off toast and tea and back to normal diets and normal activity with gratifying dispatch. ▪ Lomotil lowers intestinal motility and permits absorption of excess fluid. This usually controls diarrhea promptly. ▪ Moreover, lowered intestinal motility achieved with Lomotil often relieves the abdominal cramps and discomfort so distressing to children.

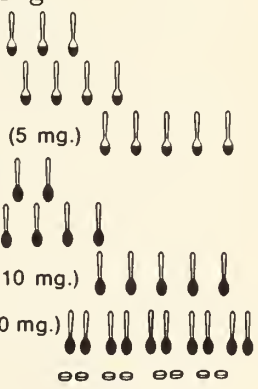
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Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

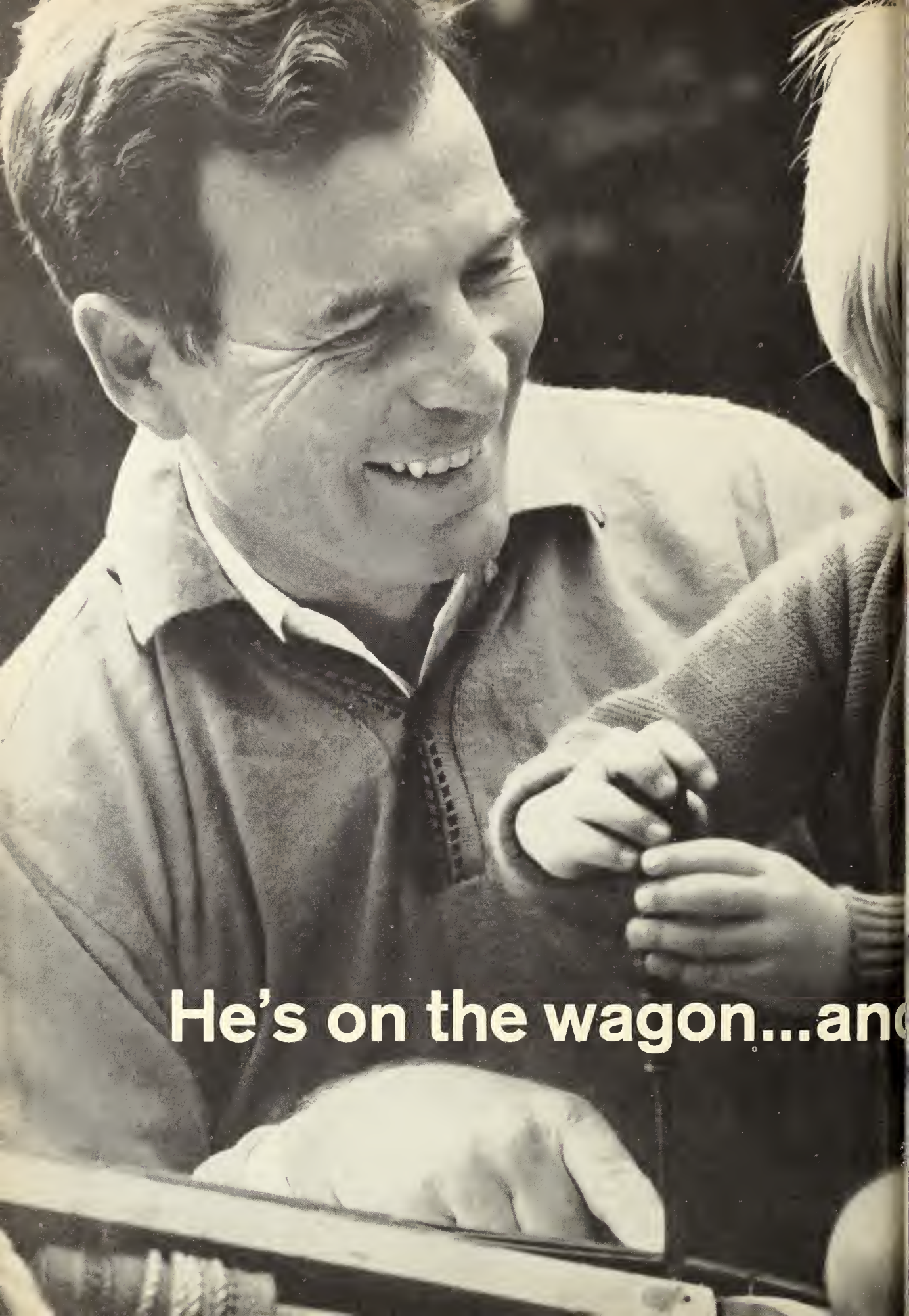
3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)
Adults: . .2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.



*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

SEARLE *Research in the Service of Medicine*


He's on the wagon...an

How well does Vistaril relieve the symptoms that plague an alcoholic during the recovery period? Doctors Knott and Beard of the Alcoholic Rehabilitation Unit, Tennessee Psychiatric Hospital and Institute, recently conducted a double-blind study comparing Vistaril and another well-established antianxiety agent with placebo in 60 chronic alcoholic patients.[1]

The investigators conclude: "It was the opinion of the staff that hydroxyzine was generally more effective than chlordiazepoxide, for the following reasons: hydroxyzine was equally if not more effective in reducing anxiety and tension and it produced less daytime sedation...."[1] (See results on succeeding pages.)

Here is new evidence that Vistaril can ease tension, allay anxiety in chronic, hospitalized alcoholic patients. *But you might also choose Vistaril for what it doesn't do.* Although not evaluated in this study, Vistaril is reported to be non-euphoriant, and its low toxicity makes it relatively safe. Best of all, Vistaril is non-habituating. To date, after more than ten years of clinical use, there have been no reports of dependency in patients receiving Vistaril.

With Vistaril, it is as easy to stop therapy as it is to start.

Vistaril®
(HYDROXYZINE PAMOATE)

the study:[1] Sixty chronic alcoholic patients were hospitalized and randomly assigned to one of three oral double-blind treatment regimens for three weeks. Twenty patients received hydroxyzine (Vistaril®), 100 mg. q.i.d.; twenty others were given chlordiazepoxide, 25 mg. q.i.d.; and the remaining twenty received placebo capsules q.i.d. The capsule code was not made known until after completion of the study and analysis of the data. Response was measured with a modification of the Brief Psychiatric Rating Scale as originally outlined by Overall and Gorham.* Subjects were rated daily by trained staff members.

SYMPTOM RATING KEY

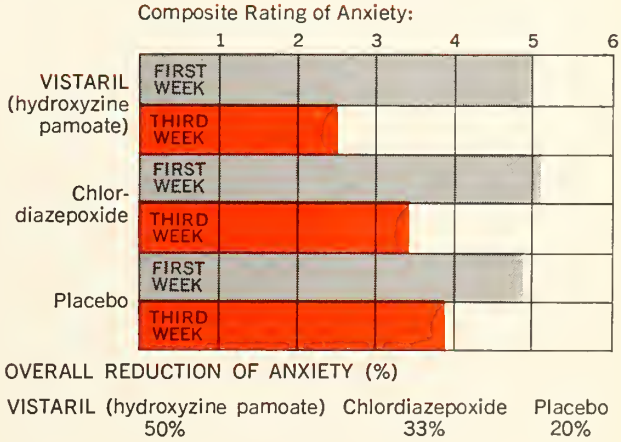
1=Not Present	4=Moderately Severe
2=Mild	5=Severe
3=Moderate	6=Extremely Severe

The figures which are given below represent the composite conclusions of the staff based on daily ratings during initial and final weeks of the study.

*Psychological Reports 10:799, 1962

the results[1] DURING FIRST WEEK DURING THIRD WEEK

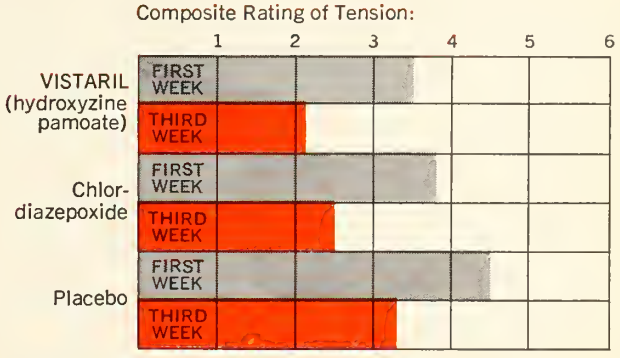
Anxiety reduced with Vistaril



OVERALL REDUCTION OF ANXIETY (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
50%	33%	20%

Tension eased with Vistaril



OVERALL REDUCTION OF TENSION (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
40%	34%	27%

PLEASE SEE LAST PAGE FOR PRESCRIBING INFORMATION

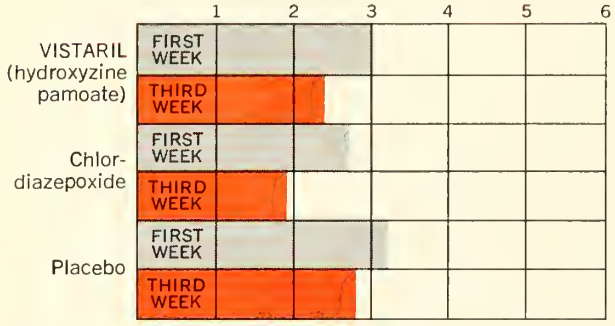
In Alcoholism...

"Both hydroxyzine and chlordiazepoxide were generally more effective than the placebo. In some aspects, hydroxyzine was superior to chlordiazepoxide, which is currently the most frequently used psychotropic drug in the management of alcoholism."[1]

DURING FIRST WEEK DURING THIRD WEEK

Depressive mood improved with chlordiazepoxide

Composite Rating of Depression:

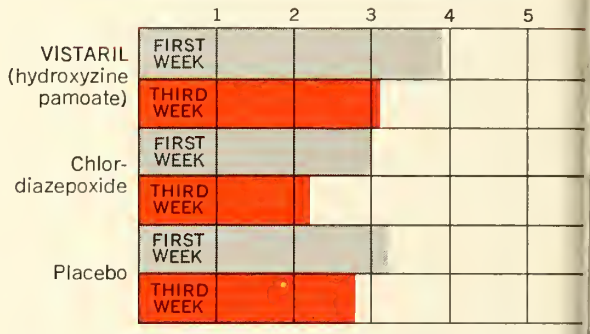


OVERALL IMPROVEMENT IN DEPRESSIVE MOOD (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
20%	30%	13%

Emotional withdrawal counteracted with chlordiazepoxide

Composite Rating of Emotional Withdrawal:

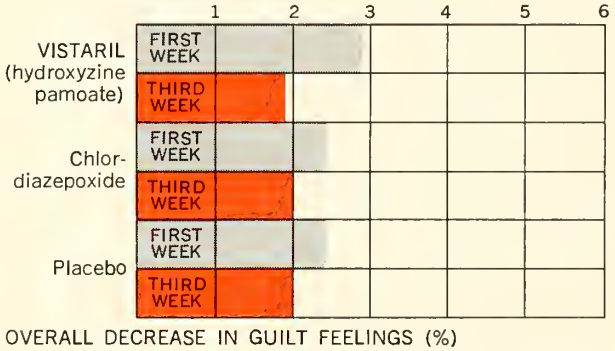


OVERALL IMPROVEMENT IN EMOTIONAL WITHDRAWAL (%

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placet
21%	27%	13%

Guilt feelings allayed with Vistaril

Composite Rating of Guilt Feelings:

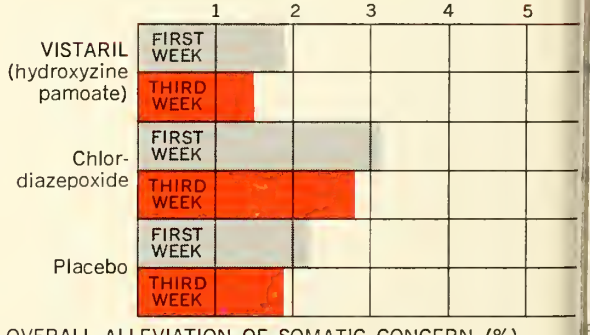


OVERALL DECREASE IN GUILT FEELINGS (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
34%	17%	17%

Somatic concern alleviated to minor degree in each group

Composite Rating of Somatic Concern:



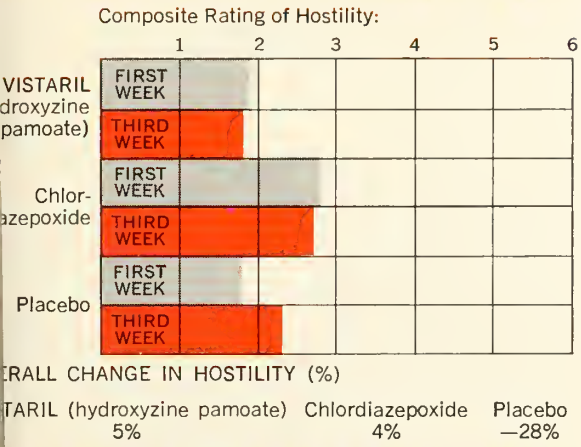
OVERALL ALLEVIATION OF SOMATIC CONCERN (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Place
17%	13%	14%

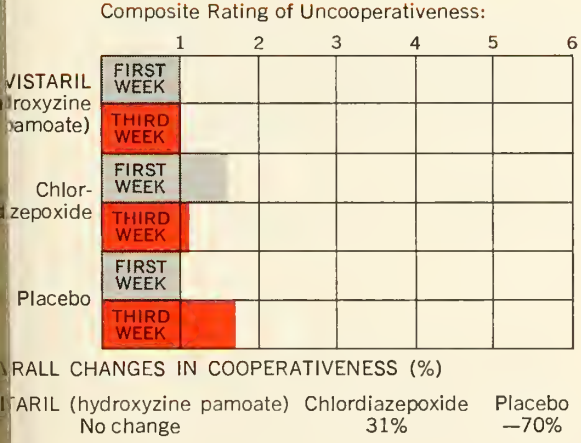
Less drowsiness with Vistaril

	Drowsiness	Dizziness	Mouth Dryness	Increased Motor Activity	Ataxia	Nausea	Comments
VISTARIL (hydroxyzine pamoate)	6 patients (mild)	3 patients (mild)	2 patients (moderate)	—	—	—	Side Effects Not Treated
Chlor-diazepoxide	10 patients (severe in 6)	4 patients (mild)	—	1 patient (moderately severe in first week but gradually subsided)	—	—	Side Effects Not Treated
Placebo	2 patients (mild)	2 patients (mild)	—	—	1 patient (mild)	2 patients (mild)	Side Effects Not Treated

Increase in hostility minimized with Vistaril and chlordiazepoxide



ooperativeness not a significant problem



n Alcoholism...

Vistaril®

HYDROXYZINE PAMOATE)

BRIEF SUMMARY

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased, as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

Reference: 1. Knott, D.H. and Beard, J.D.: GP 36:118, September, 1967.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A



1968 . . .
OSMA ANNUAL MEETING PREVIEW . . .

See You in Cincinnati
Plan Now to Attend

CINCINNATI will provide the setting for the 1968 Annual Meeting of the Ohio State Medical Association, May 13 - 17, and the new Cincinnati-Exposition Center and Netherland-Hilton Hotel will house most of the program events. In fact, this is the first time the Association has had an opportunity to use the Cincinnati-Exposition Center — the most modern convention facilities available — conveniently located in the heart of the downtown area.

The Netherland-Hilton will be the headquarters hotel. Other fine hotels are available also in the downtown area. Note the Hotel Reservation Page in this issue — a convenient means of making hotel reservations — NOW! Don't be disappointed — make your reservations early!

More detailed information on highlights of the meeting will be given in coming issues of *The Journal*. The entire program, with topics, names of speakers, etc., will be mailed to members of the Association prior to the Annual Meeting.

The following preview is published — subject possibly to a few changes — for the convenience of members and to acquaint readers with the format of the program.

Monday Afternoon, May 13

District Caucuses to be held by each district councilor. Rooms will be assigned for their use.

Monday Evening, May 13

House of Delegates registration followed by a buffet dinner.

First Session of the OSMA House of Delegates beginning at 7:00 P. M.

Tuesday Morning, May 14

Registration of Exhibitors.

Meetings of House of Delegates Reference Committees.

12:00 NOON All Exhibits Open.

Tuesday Afternoon, May 14

General Registration Opens.

Ohio Health Commissioners Institute.

Continuation of meetings of House of Delegates Reference Committees.

General Session — "Medical Hooey" — Program sponsored by the OSMA Committee on Environmental and Public Health.

Tuesday Evening, May 14

Council dinner honoring OSMA Past Presidents.

Meeting of the Ohio Delegation to the American Medical Association.

Wednesday Morning, May 15

General Session — Program to be presented by the Ohio Division, Inc., American Cancer Society.

Ohio Health Commissioners Institute.

Business meeting of the Ohio Ear, Nose, and Throat Society.

Business meeting of the Ohio Ophthalmological Society followed by a noon luncheon.

General Session — Program sponsored by the OSMA Section on Plastic Surgery.

Wednesday Afternoon, May 15

General Session — Edward R. Annis, M. D., Past President, American Medical Association — "Medicare Plus Two Years — How Is the Medical Profession Faring?"

Combined meeting of the Section on Anesthesiology and Ohio Chapter, American College of Chest Physicians.

Section on Ear, Nose, and Throat and the Ohio Ear, Nose, and Throat Society.

Section on Ophthalmology and the Ohio Ophthalmological Society.

Section on Hospital Directors of Medical Education.

Ohio Health Commissioners Institute.

Special General Session — Panel program on "Government Medical Care Programs and OSMA Policies" sponsored by the OSMA Committee on Government Medical Care Programs.

Wednesday Evening, May 15

Gaslight Party for all OSMA Members, Exhibitors, and Guests.

Thursday Morning, May 16

Breakfast meeting Ohio Committee on Trauma, American College of Surgeons.

General Session — Program sponsored by the Ohio State Heart Association.

Ohio Health Commissioners Institute.

Executive Committee meeting, Ohio Committee on Trauma, American College of Surgeons.

General Session — "The Treatment of Chronic Renal Failure" to be presented by Victor Vertes, M. D., sponsored by the Ohio State Medical Association.

Ohio Medical Political Action Committee Luncheon — guest speaker, The Honorable Robert Taft, Jr.

Thursday Afternoon, May 16

General Session — "Emergency Room Problems," panel program sponsored by the Ohio Committee on Trauma, American College of Surgeons.

Section on the General Practice of Medicine.

Combined meeting of the Section on Internal Medicine and Radiology.

Section on Obstetrics and Gynecology.

Section on Occupational Medicine.

Section on Physical Medicine and the Ohio Society of Physical Medicine and Rehabilitation.

Ohio Health Commissioners Institute.

Thursday Evening, May 16

German Smorgasbörd for members of the OSMA House of Delegates, official guests, and exhibitors.

Final Business Session of the House of Delegates followed by Speaker Milford O. Rouse, M. D., President, American Medical Association.

Friday Morning, May 17

General Session — "The Pill" — Program sponsored by the OSMA Committee on Medicine and Religion.

Conference on Laboratory Medicine — "You Can Teach an Old Dog New Tricks," sponsored by the Committee on Laboratory Medicine.

General Session — "Management Problems in Juvenile Diabetes"—Program sponsored by the University of Cincinnati College of Medicine.

Ohio Psychiatric Association Luncheon Meeting.

Friday Afternoon, May 17

Section on Neurological Surgery and Ohio Neurosurgical Society.

Section on Orthopaedic Surgery and Ohio Orthopaedic Society.

Section on Pathology and Ohio Society of Pathologists.

Section on Pediatrics and Ohio Chapter, American Academy of Pediatrics.

Section on Psychiatry and Neurology and Ohio Psychiatric Association.

Provisions in the OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cincinnati, May 13-17.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 18.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 1 (a), entitled "Nomination of President-Elect."

Four East Palestine physicians were honored at Veterans Day observances by the American Legion for dedicated service to the community. They are Dr. John S. Atchinson, Dr. William S. Elliott, Dr. Charles F. Kissinger, and Dr. Alexander M. Simpson.

Dr. Emanuel Wolinksy, Cleveland, was speaker for the November 14 dinner meeting of the Fort Steuben Academy of Medicine, held in the Fort Steuben Hotel, Steubenville. His subject was, "Practical Aspects of Choosing and Using Antibiotics."

GENERAL SESSION

WEDNESDAY, MAY 15
1:30 P.M.

ROOM NO. 209

Cincinnati-Exposition Center

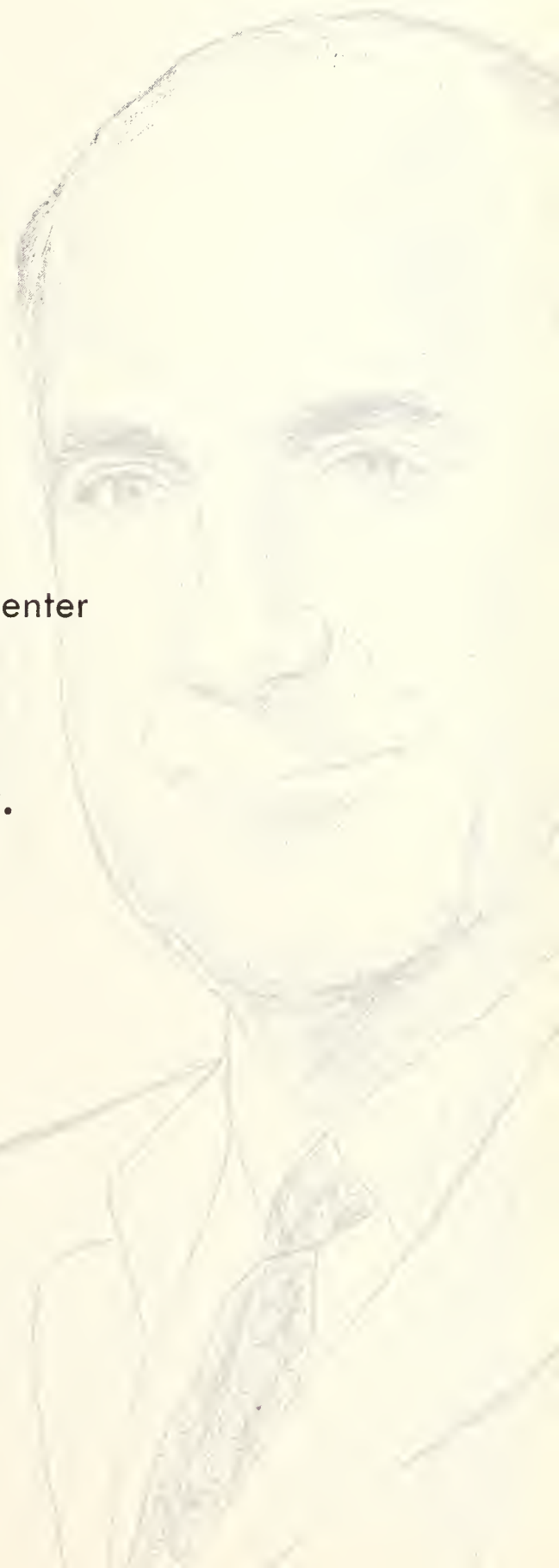
Featuring

EDWARD R. ANNIS, M.D.

PAST PRESIDENT,
AMERICAN MEDICAL ASSOCIATION

MEDICARE PLUS TWO YEARS

How is the Medical
Profession Faring?



GASLIGHT PARTY

Netherland Hilton Hotel
(Pavilion Caprice Room)

Wednesday, May 15, 1968
7:00 P.M. until ? ? ?

GAY 90 YEARS



What ! 5c Beer is back? ?



Who has got the golden garter?



Bring your favorite flapper girl.



All **this** for only $8.00 per person?

ENTERTAINMENT! The Gaslight Road Show —
(Direct from Chicago's Gaslight Club)
Al "Mr. Banjo" Myers and his band of entertainers
"The Back Room Boys"

DANCING! CONTESTS! PRIZES! SNACKS!

MARK YOUR CALENDAR NOW! ! !

We Need YOU to Help Make '68
THE YEAR OF DECISION!

Attend - - -

THE ANNUAL OMPAC LUNCHEON

THURSDAY, MAY 16
Room 210
Cincinnati-Exposition Center


Congressman Taft

Speaker.... The Honorable
ROBERT TAFT, JR.
FIRST OHIO DISTRICT

11:30 A. M.	Cash Bar
12:00 Noon	Luncheon
12:45 P. M.	"Lets Take a Look at the Record!"
	Progress Report — Frank H. Mayfield, M. D., Chairman, OMPAC Board
1:00 P. M.	After Luncheon Speaker — Hon. Robert Taft, Jr.

Tickets . . . $5.00 per person

GASLIGHT PARTY

Complete and Forward to:
THE OHIO STATE MEDICAL ASSOCIATION
17 South High Street, Suite 500
Columbus, Ohio 43215

OMPAC LUNCHEON

Enclosed is $ _____ to pay for:

_____ Tickets to Gaslight Party ($8.00 per person)

_____ Tickets to OMPAC Luncheon ($5.00 per person)

Wednesday, May 15
Netherland Hilton Hotel
7:00 P.M.
Featuring Chicago's
GASLIGHT ROADSHOW

Thursday, May 16
Cincinnati-Exposition Center
11:30 A.M.
Featuring Congressman
ROBERT TAFT, JR.

Please make checks payable to: **THE OHIO STATE MEDICAL ASSOCIATION**

Fun!
Frolic!

Name: _____

Street Address: _____

City and State: _____



CALL FOR ENTRIES

SCIENTIFIC AND HEALTH EDUCATION EXHIBITS

1968 Annual Meeting, Ohio State Medical Association

May 13 - 17, Cincinnati, Ohio

OUTSTANDING among the features of the 1968 Annual Meeting of the Ohio State Medical Association, May 13-17, Cincinnati, Ohio (exhibit days May 14-17) will be the Scientific and Health Education Exhibits. This will be the first time OSMA will use the excellent facilities of the Cincinnati-Exposition Center. Let's make 1968 a record-breaking year on exhibits.

Presentations will be limited to (1) exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) out-of-state physicians or out-of-state agencies on invitation; (3) voluntary health organizations.

Each exhibitor will be provided with a booth or wall space, a standard sign, necessary electrical outlets, shelves, transparency cases, and a reasonable amount of furniture. If additional special facilities, equipment, or furniture are needed for the proper showing of the exhibit, the exhibitor should consult the chairman of the committee, Samuel Saslaw, M. D., and obtain his approval. The Association will not pay for special facilities, equipment, and furniture unless the request is approved in advance by the chairman.

On the opposite page will be found an application blank. If you have material suitable for an exhibit, send in an application. If you know of a colleague or group of physicians who have interesting material to display, suggest that they do the same. Deadline for entries in the Scientific and Health Education Exhibits are January 30, 1968.

A watchman will be on duty during the meeting but it is agreed that exhibitors will idemnify and hold harmless the Ohio State Medical Association from all liability which may ensue from any cause whatsoever.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The picture on the facing page shows the type of booth which will be provided.

The booths will be of uniform color and design. Back and side walls will be pegboard, making them extremely functional for accommodating all kinds of charts and specimens. Blue fluorescent fixtures are a part of the background and will be spaced on each exhibit to give adequate lighting. If special lighting is needed, this should be noted in application for space.

APPLICATION FOR SPACE

SCIENTIFIC AND HEALTH EDUCATION EXHIBITS
1968 ANNUAL MEETING, OHIO STATE MEDICAL ASSOCIATION
Cincinnati-Exposition Center, Cincinnati, Ohio, May 13 - 17

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

_____

Institution (if desired): _____

City _____

3. Do you have a built-in exhibit? _____

4. Description of Exhibit: (Attach 200 word description to this blank for use in Annual Meeting Program)

5. Exhibit will consist of the following: (Check which)

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____
(Describe)

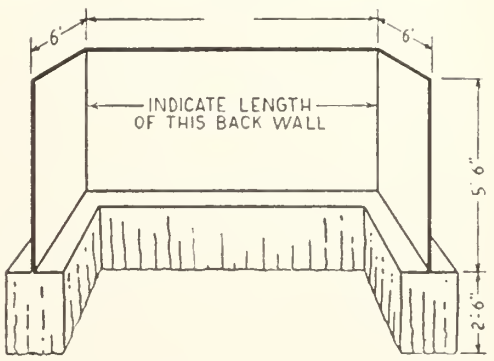
6. Booth Requirements:

Amount of wall space needed? _____

Back wall _____ Side walls _____

Square feet needed? _____

Shelf desired? (yes or no) _____



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

7. Transparency Cases:

Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____

_____

_____

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date _____ _____
Signature of Applicant

_____
Mailing Address, Street

_____
City, State, Zip Code

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC WORK, OHIO STATE MEDICAL ASSOCIATION, 17 SOUTH HIGH STREET, SUITE 500, COLUMBUS, OHIO 43215

DEADLINE FOR FILING APPLICATIONS, JANUARY 30, 1968

Leading Downtown Cincinnati Hotels
and Prevailing Rates

NETHERLAND HILTON HOTEL
5th and Race St.
Phone 621-3800
(OSMA Headquarters)

Singles	$10.50-$20.00
Doubles	$14.50-$18.00
Twins	$17.00-$25.00

TERRACE HILTON HOTEL
15 West 6th St.
Phone 381-4000
(Woman's Auxiliary Headquarters)

Singles	$14.25
Doubles (none available)	
Twins	$19.00

SHERATON-GIBSON HOTEL
421 Walnut Street
Phone 621-6600

Singles	$ 9.75-$15.75
Doubles	$13.75-$19.75
Twins	$13.75-$19.75

HOLIDAY INN — DOWNTOWN
8th and Linn St.
Phone 241-8660

Singles	$12.00
Doubles	$16.00
Twins	$16.00

Make Your HOTEL RESERVATIONS

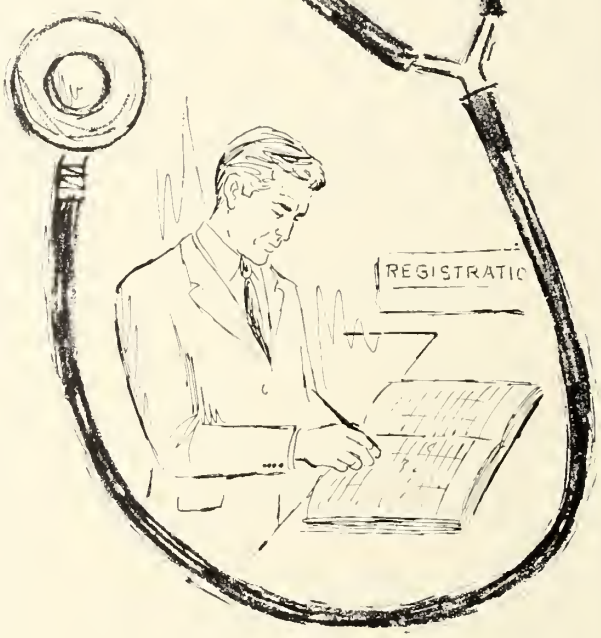
FOR THE

1968 OSMA ANNUAL MEETING

Cincinnati May 13-17

All rotes subject
to chonge

If you plon to share a room,
pleose indicote nome of
roommate.



HOTEL RESERVATION BLANK
(Mail to Hotel of Choice)

_____
(Name of Hotel)

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'68 the Year of Decision ...

Ohio Medical Political Action Committee Builds Strength For Coming Elections: Needs Total Backing of Physicians

THIS YEAR — 1968 — is a General Election Year. The coming elections offer many real challenges to the medical profession, and to its Strong Right Arm in Ohio — the Ohio Medical Political Action Committee (OMPAC).

OMPAC faced its first real test of strength in 1966 and proved its merit. Now it is entering an even more crucial proving ground—its ability to rally additional members for the big drive toward the 1968 General Election.

With the backing of a large percentage of Ohio physicians, OMPAC can throw increasing strength on the side of good candidates for legislative offices.

"The majority of Ohio's representatives in the U. S. Congress are persons of ability, courage, and integrity," wrote Dr. Frank H. Mayfield, chairman of the OMPAC Board, in a recent letter to Ohio doctors. "It will take hard work to re-elect them.

Also in 1968 a new Ohio General Assembly will be elected. "What goes on in the State Legislature is of vital importance to each Ohio physician," Dr. Mayfield continued. "Because of this, it is imperative that men and women of high qualifications be chosen for seats in the Ohio Senate and House."

"Organized financial giving to worthy candidates at election time is one way for the medical profession to make its voice heard in politics," Dr. Mayfield's letter continued. "This, plus individual work on the part of physicians and their wives for candidates, makes the medical profession a potent factor in political affairs—a factor to be reckoned with not only in elections but in legislative matters as well."

Dr. Mayfield concluded his letter with an urge for each Ohio physician to make a $25.00 contribution to OMPAC for 1968. This amount may be paid along with Society dues, in which case the local treasurer will forward the contribution to OMPAC at P. O. Box 5617, Columbus, Ohio 43221.

Look at the Record

In its first real test of strength, during the 1966 General Election year, OMPAC chalked up an excellent score. Here is the 1966 record:

- Almost 30 per cent of the physicians of Ohio made financial contributions to OMPAC-AMPAC. Contributions totalled approximately $75,000.00.
- OPMAC rated high in the national ranking of states with respect to total funds raised. It was third, exceeded only by Pennsylvania and Illinois.
- OMPAC made political contributions totalling $67,350.00. Of this amount, $58,000 went to support committees of candidates for the U.S. Congress and $9,350.00 to committees working for candidates for the Ohio Legislature.
- Of the total number of candidates for Congress and the Ohio General Assembly, OMPAC made

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financial contributions to 51. Of this number, 45 were elected.

- OMPAC made financial contributions to the local support committees of ten Ohio candidates for the United States House of Representatives.
- Of the Congressional candidates who were supported financially by OMPAC, nine were elected at the General Election on November 8.
- OMPAC also made financial contributions to the campaign committees of 14 candidates for the Ohio Senate and the campaign committees of 27 candidates for the Ohio House of Representatives.
- Twelve Ohio Senatorial candidates who were aided by OMPAC were elected.
- Twenty-four candidates for the Ohio House who received financial help from OMPAC were elected.

A substantial number of other successful candidates for both the Congress, the Ohio Senate and the Ohio House, although not receiving financial aid from OMPAC, did receive fine support from individual physicians in their districts. The standing policy of OMPAC was to make financial contributions only to candidates engaged in unusually close races and in need of funds over and above those received from their party's treasury or from interested friends and supporters.

More physicians and their wives took active parts in political affairs in Ohio in 1966 than ever before, with the possible exception of 1950 when the notorious Taft-Ferguson battle occupied the Ohio—and national—spotlight. Many physicians made personal contributions to candidates as they have been doing regularly over the years.

In 1967, in spite of the off-year as far as General Elections were concerned, membership in OMPAC was good—2,875—again approaching one-third of State Association membership. (It was 2989 in 1966.) This off-year backing of the Strong Right Arm indicates doctors' determination to make themselves felt in the political arena.

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THE PRESIDENT REPORTS . . .

. . . on Certain Factors Dominating the Health Care Field and Their Impact on the Medical Profession

ROBERT E. HOWARD, M. D., OSMA President

SIX MONTHS have rapidly passed since taking office, and 18 months of Medicare has come to pass for all of us. What has happened? Public Law 89-97 became a law without many of the lawmakers having time to read the fine print hastily written and revised by Wilbur Cohen of HEW shortly before passage.

The Pre-Medicare fear, shared by the government itself, of overcrowding of hospitals did not occur for one reason only — that the hospitals were already crowded. However, there has been a gradual increase of older citizens in hospital bed occupancy, excluding many younger people needing hospital care, who must wait, although they are paying the bill for all through taxes. There has been added red tape and delays in payment in the experience of both hospitals and physicians. However, the intermediaries have made an honest attempt to improve these problems. HEW, through frequent changes of rules, regulations and local welfare's slow accounting methods and procedures, have caused reimbursement under Medicaid for the needy to be hopeless and critical.

Fortunately, as in the past, and contrary to HEW's statement to the President in February, 1967, charity Medicine does exist in Ohio, and the doctors are still caring for the poor without adequate compensation. Actual costs for Medicare and in the two states where Medicaid has been fully implemented are high and are above government predictions, as we expected. The true analysis will show millions of 65 and over patients have received a good quality of care as they did before Medicare; and 80 per cent of their doctors' bills and all of their hospital bills, except the deductibles, were paid for by the Federal taxes, when they were perfectly able and willing to pay for those services themselves.

This we objected to before Medicare, and we still object to such a philosophy. I would be quick to remind those administrators of Medicare who are now publishing for public consumption statistical facts related to the large number of patients receiving care under Medicare, that I haven't seen a single reference by SSA to the percentage of those who could or would have willingly paid their own bills, so that at least the needy who are on welfare and on assistance programs could have had equal status and reimbursement for health care. Yet these same administrators are now literally throwing in the crying towel because of total costs.

I am hoping the physicians of Ohio will not falter and fall in line with HEW and accept assignment since direct billing is the only feasible way to keep our patient-doctor relationship from deteriorating. Bill 12080 being considered in Congress may have passed by the time this is published, and it is my hope that after the Ways and Means Committee and the House and Senate revise the Medicare law that some of the defects will be eliminated.

Title XIX cannot be implemented and doctors reimbursed for services in Ohio as long as:

(1) The Director of Public Welfare and top officials of State government do not wish to include total health care for the indigent in the State's fiscal budget.

(2) The Department of Public Welfare administers the mechanics instead of the intermediary of Medicare who is stalled in handling the volume of bills and payments.

I am informed that a total of 33 states have implemented procedures for payment of physicians' fees under Title XIX. Of these, 22 have designated a State agency, generally Welfare or Health, to administer the program, including payment of physicians' fees; 11 have designated Blue Shield for this purpose, and handle the physicians' fees on the definite national trend of the usual, customary, and reasonable basis. It is hoped that our state may realize, before it is too late, that the doctor should be reimbursed on an equal status to hospitals and nursing homes.

Comprehensive Health Care Planning and Services, P. L. 89-749

This program of HEW is locally oriented in Ohio into, at present, seven areawide health facility agencies. The goal of these agencies is to come up with complete programs of health care on a basis of present and future local needs. The Health Council selected by Dr. Emmett Arnold will review and pass on plans submitted before they are referred to the Surgeon General of Public Health for final approval. Mr. Sewell O. Milliken has been selected by Dr. Arnold to head this program in his Health Depart-

ment and all questions should be forwarded to him for the present. The OSMA's eight policy statements for all government medical care programs must be fundamentally considered in P. L. 89-749 programs.

"Generic Equivalent—a Misguided Myth"

Two of the most loyal friends of the medical profession are ethical pharmacists and pharmaceutical houses. The basis of friendship is understanding of each others' problems. Both sympathy toward and understanding are based on knowledge.

Heart, Cancer, and Stroke — P. L. 239

Since this was enacted into law October 6, 1965, several grants have been approved in Ohio and others are being considered for continuing medical education in co-ordination of programs in training, research, and demonstration relating to Heart, Cancer, and Stroke. The Ohio Valley Regional Medical Program Council has discussed the possibility of private funding to avoid the problem of government involvement. It was suggested a survey be carried out to find the needs and desires of men actually in practice before implementing an areawide program. In the meantime, continuing educational programs should be — and are being — continued in hospitals and medical organizations.

Nursing Home, County Home or Extended Care Facility Custodial versus Skilled and Medical Service Care

Recent problems have risen in these facilities due to Social Security's failure to inform, explain, or educate the public fully on Medicare regulations and procedures. This has caused a confused public and unwarranted vicious attacks on members of the medical profession for situations that are created by the Medicare law and regulations, **not** by the medical profession.

The medical profession wants clearly understood the role and responsibilities of the various health care persons and agencies in the Medicare program.

The role of the physician is clearly defined, as are his legal and ethical responsibilities.

The Congress, when it enacted the Medicare Law, definitely and pointedly declared in both the purpose of the law and the intent of Congress that payment be made only for services that are absolutely necessary.

Congress further declared that the physician must certify, in his best ethical and professional judgment, that medical and other skilled services are or were medically necessary.

Congress clearly stated that payment for services for eligible patients in extended care facilities was to be made only for necessary skilled services, and not for custodial services.

It is a violation of the *Principles of Medical Ethics* for a doctor of medicine to provide or to prescribe unnecessary services or ancillary facilities.

Under the Ohio Revised Code, a violation of the *Principles of Medical Ethics* may be construed legally as gross unprofessional conduct, for which the physician is subject to revocation or suspension of his license to practice his profession in Ohio.

The Ohio State Medical Association wants it clearly understood that it is not the physician who decides whether or not a person's health care expenses will be paid from Medicare funds. The physician's only decision is one of a medical nature, and not an economic matter.

The decision as to payment of benefits is within the authority of the Social Security Administration, of which the medical profession is not a part.

Congress specifically charged the utilization review committee with the legal responsibility of preventing unnecessary utilization of the Medicare program.

Congress further specified that Medicare was not and could not be used as a means of payment for custodial care of a patient, but only certain medical, surgical, and other skilled services.

If operators of extended care facilities, such as nursing homes and county homes, want Medicare to pay for custodial care, then their recourse is with the Congress. They cannot and they must not expect a physician to warp his best professional judgment in order that these operators receive payment for services that were not legally and medically necessary.

Those persons who disagree with the laws and federal regulations that govern Medicare cannot change these laws and regulations by attacking the medical profession. Their source of relief is with the Congress.

The definition of custodial versus skilled care has been recently defined in the November issue of *The Ohio State Medical Journal* (beginning on page 1517).

We in Ohio are very proud of the leadership in the AMA Woman's Auxiliary of Mrs. Karl Ritter, of Lima, Ohio, and in the State of Mrs. Paul Sauvageot in carrying out OSMA programs, especially the AMA-ERF and OMPAC activity and enrollment.

The installation in October, 1967, of Mrs. Margaret Swank, of Newark, Ohio, as President of American Association of Medical Assistants gives us additional medical leadership and cooperation through our medical assistants and their educational program.

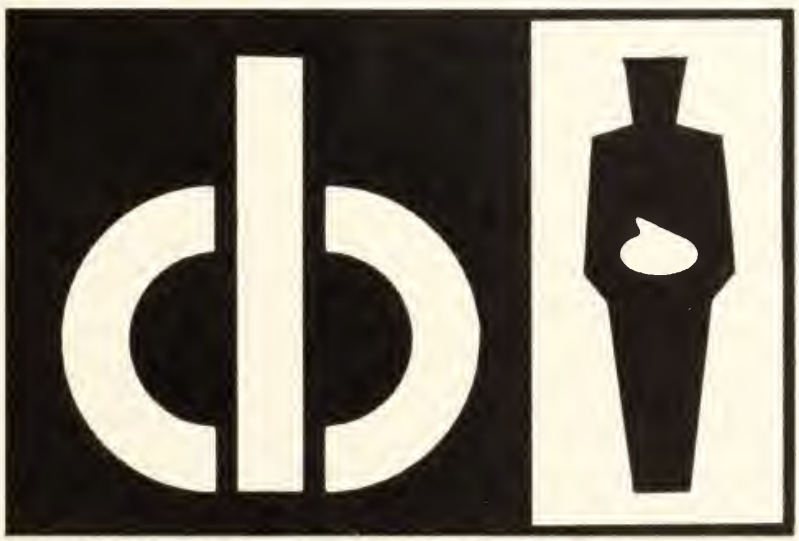
I would like to personally thank the OSMA staff and all physician members that have contributed to our medical legislative endeavors this year and to our policy decisions through committee and Council actions in the interim between the House of Delegates and Annual Meetings.

I would also like to thank our AMA Delegation and Dr. Milford Rouse for the strong stand for direct billing and their concept of freedom of medicine from government domination.

In closing, I would welcome any suggestions or criticisms to improve our organization.

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Open Letter To

Physicians of the Ohio State Medical Association

I WOULD LIKE very much to "talk" with you for a few minutes regarding the Ohio State Society of Medical Assistants. I would also like to further request that you have your medical assistants read this article. It is my firm feeling that participation in this Society could make the difference between having an ordinary office girl and in having an excellent office girl. Please read on.

Many years ago, William Shakespeare wrote the oft repeated phrase, "to be, or not to be?" Today this question certainly might be applied to the many organizations that exist. Should an organization "be," or should it "not be"? I feel the main criteria to be used in answering this query should include consideration of the following questions:

- Is the organization worthwhile?
- Does the organization have a purpose?
- Does the organization's service to others— and to its own members — justify its existence?
- Does history show that the organization has accomplished anything?

Several years ago, Dr. Robert Howard (current President of our Ohio State Medical Association) asked me to serve as one of his associates on the Advisory Board to the OSSMA. I reluctantly agreed because I, at that time, felt that this organization was probably a group of gals dedicated to furthering their own selfish interests by holding discussions regarding salaries, vacations, sick leave, etc. This is **not true.**

Again at Dr. Robert Howard's request, I attended the annual meeting of the OSSMA in Akron in 1966 — and was astonished at what I saw. The Board of Directors held its initial meeting at 8 o'clock in the evening with a full agenda, much discussion, and much participation. There was no bickering — there was no "union shop talk" — the members met issues head-on and accomplished their purpose. The Board of Directors met until the wee hours in the morning on matters which they considered of prime importance.

The first House of Delegates meeting was called to order early in the morning and was very properly conducted. Workshops were discussed — seminars were planned — committees were appointed — projects were born. No delegates could have worked harder. (Again — there was no discussion of salaries, vacations, sick leave, etc.) The only purpose seemed to be to construct and develop plans to help educate the members of OSSMA to be better medical assistants. Various meetings were held on subjects pertaining to telephone etiquette, care of the patient, how to handle the office in the doctor's absence, the proper billing technique, how to efficiently complete insurance forms, and instructions regarding Medicare, etc. — absolutely fantastic!

It has been my observation that these medical assistants who belong to the OSSMA talk about "their" office and "their" doctors. They are not just performing a job. They are proud and loyal to their physician, to the medical profession, and to their position. Speaking of loyalty, I would like to quote an article written by Elbert Hubbard and titled "Loyalty."

> "If you work for a man, in Heaven's name work for him; speak well of him and stand by the institution he represents. Remember — An ounce of loyalty is worth a pound of cleverness. If you must growl, condemn and eternally find fault, why — resign your position and when you are on the outside, damn to your heart's content — but as long as you are a part of the institution do not condemn it. If you do, the first high wind that comes along will blow you away and probably you will never know why."

The annual meeting concluded on a Sunday with a brunch, installation of officers, some very impressive ceremonies, etc. Even this "concluding meeting" was followed by another Board meeting.

As practicing physicians, we often do not have the time — or either don't take the time — to teach our medical assistants those things which would help

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them, our practices, and ourselves. The OSSMA will do this for us. There are now 12 local County Societies in Ohio and there are also many members-at-large in counties which do not have a local chapter. The total membership is about 565 medical assistants and this includes approximately 52 new members since May 1967.

I think it would be to your advantage to interest your medical assistant in joining this organization. The total dues are usually from $16.00 to $20.00 per year. This includes local, state, and national dues.

The current President is Miss Laura L. Lockhart, 21 South Highland Avenue, Apt. 6, Akron, Ohio 44303. Laura will be glad to answer your questions. She will visit your county in helping to establish a group and she will provide whatever information you or your girls desire.

I have been converted. I am certainly a believer in the Ohio State Society of Medical Assistants. I feel sure that you will feel the same way if you and your girls give this organization a chance to prove its value.

Thanks a lot for "listening."

Richard L. Fulton, M. D.
Chairman, OSMA Advisory Committee
to the OSSMA.

Visitors to AMA Headquarters Are Always Welcome

Physicians, their wives, and guests have a standing invitation to visit the American Medical Association headquarters offices at 535 N. Dearborn Street in Chicago, any time during office hours. In our opinion, such a visit would be not only an interesting venture but an educational tour. The AMA's activities and programs are vast, and a tour of the nine-floor nerve center would be a revelation to those who have not seen it.

Tours are conducted by specially trained headquarters employees, who seek to acquaint visitors with the organizational structure of the AMA, major areas of activity and many of the services available to physicians and the public.

During the third quarter of 1967 nearly 500 persons were conducted on tours of the headquarters offices. This unusually heavy schedule, almost equaling tour attendance for the entire preceding year, indicates increasing personal interest in the AMA by individual physicians. Approximately 60 per cent of those taking tours are physicians. The remainder are medical society personnel, members of the Woman's Auxiliary, medical assistants, those employed in allied health professions and students.

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MEDICINE AND PHARMACY:

A Common Goal

By JOHN WILLIAM MANNINO, President
Ohio State Pharmaceutical Association

FOR THE PAST several years the leaders of Ohio medicine and pharmacy have been alerting their members to the forces that are constantly attempting to disrupt the quality of health care in this country. These forces, if left unchecked, will destroy medicine and pharmacy — and consequently the means of delivering quality health care to our citizens.

Too often in the past medicine and pharmacy have been preoccupied with petty interprofessional bickering. If this is allowed to continue we will only aid those who seek to destroy our professional freedom. There may always be minor areas of disagreement between our two professions, but to air our disagreements in public can lead only to disaster.

The arena for discussion and solution of these differences must be interprofessional. Medicine and pharmacy may never agree one-hundred per cent on all matters, and this is as it should be. Conversely, there will always be large areas of agreement between these two professions, as well as a mutual sharing of similar problems.

In early November I met with Dr. Robert E. Howard, President of the Ohio State Medical Association; as well as several members of our respective staffs. At this meeting both Dr. Howard and I expressed our desire to improve the interprofessional relations between medicine and pharmacy. As a result of this meeting, I would like to believe that medicine and pharmacy in Ohio are entering a new era. This era will find these two professions working together a common goal: to provide ever better health care for the citizens of Ohio.

We must be ever alert to the relentless attacks of government and others on the Health Care Professions. Only by means of joint action can medicine and pharmacy resist all the attacks and maneuvers by the Office of Economic Opportunity and other agencies that would attempt to destroy the established procedures for providing health care. These established procedures have provided the citizens of this country with medical care second to none.

The theme today is change. Change we must and will, but only when change means improved health care, not when change means political expediency.

To meet the problems and challenges that face our professions, to grow with these changes, and to insure that we do not perish because of them, medicine and pharmacy **must** establish, once and for all, a strong continuing Interprofessional Relations Committee. The foundation for this was established when the presidents of the Ohio State Medical Association and the Ohio State Pharmaceutical Association met in November.

The leaders of medicine and pharmacy can construct a strong program on this foundation. However, we cannot insure its success. This will be dependent upon each individual physician and each individual pharmacist believing and living in a spirit of understanding and empathy.

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Ad Astra

Howard Thomas Baumgardner, M. D., Akron; Loyola University Stritch School of Medicine, 1953; aged 42; died November 27; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Internal Medicine. An earlier resident of Akron, Dr. Baumgardner returned there to practice about 10 years ago, and specialized in internal medicine. He was a veteran of World War II, having served in the Marine Corps. A member of the Catholic Church and the Holy Name Society, he is survived by his widow, three sons, four daughters, his father, and three sisters.

Emerson Bowers Beery, M. D., Euclid; Hahnemann Medical College of Philadelphia, 1941; aged 54; died November 5; member of the Ohio State Medical Association, the American Medical Association, and the American College of Obstetricians and Gynecologists; diplomate of the American Board of Obstetrics and Gynecology. Dr. Beery began practice in the Cleveland area in 1946, after a tour of duty overseas during World War II. He was a native of west-central Ohio, a son of the late Dr. and Mrs. W. H. Beery. Dr. Walter C. Beery, of Lima, is a brother. Other survivors are his widow, two daughters, a son, two sisters, and another brother.

Corbin Lee Crouch, M. D., East Sparta; University of Arkansas School of Medicine; aged 61; died November 24 as the result of a traffic accident; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Crouch opened his practice in the Stark County community in 1946, after serving in the Medical Corps during World War II. Active in community affairs, he was a member of the American Legion, the Presbyterian Church, several Masonic bodies. Survivors include his widow, and three sisters.

Bernard Cecil Dienger, M. D., Cincinnati; Creighton University School of Medicine, 1939; aged 51; died November 16; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Otolaryngology; former president of the Cincinnati Otolaryngological Society. A practitioner in Cincinnati for about 20 years, Dr. Dienger specialized in the eye, ear, nose, and throat field. He was a veteran of World War II and served in the Army Medical Corps from 1941 to 1946. Survivors include his widow, five sons, four daughters, and a sister.

Rafael Dominguez, M. D., Cleveland Heights; Faculty of Medicine of the National University, Bogoto, Colombia, 1915; aged 75; died November 24; member of the Ohio State Medical Association, the American Medical Association, and the American Association of Pathologists and Bacteriologists. Director of laboratories in Doctors Hospital since January 1966, Dr. Dominguez was formerly pathologist and director of laboratories at St. Luke's Hospital for many years, and was on the faculty of the Institute of Pathology at Western Reserve University. Among survivors are his widow, two daughters, two brothers, and four sisters.

George Hayes Gale, M. D., Newport (Washington County); Jefferson Medical College of Philadelphia, 1906; aged 84; died November 10; member of the Ohio State Medical Association and the American Medical Association. A native of the Newport area, Dr. Gale devoted a lifetime to practice there. He was active in numerous community affairs, was a member of the American Legion, as a veteran of World War I, a member of the Catholic Church, the Knights of Columbus; also former member and president of the local board of education. In 1957 he was selected to play the leading role in one of Ralph Edwards' original "This Is Your Life" programs on a national telecast. His father, the late Dr. George Thomas Gale practiced in the vicinity, and a late brother, Dr. Larry Gale also practiced there. For a number of years he was professionally associated with his son, Dr. Larry B. Gale who survives. Also surviving are three daughters, and another son.

Norbert Stanley Greene, M. D., Cleveland; Georgetown University School of Medicine, 1931; aged 62; died November 3; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Chest Physicians. A practitioner for some 25 years in Cleveland, Dr. Greene specialized in the fields of internal medicine and chest diseases. During World War II he served in the Army Medical Corps and attained the rank of lieutenant colonel. Among

(Continued on Page 116)

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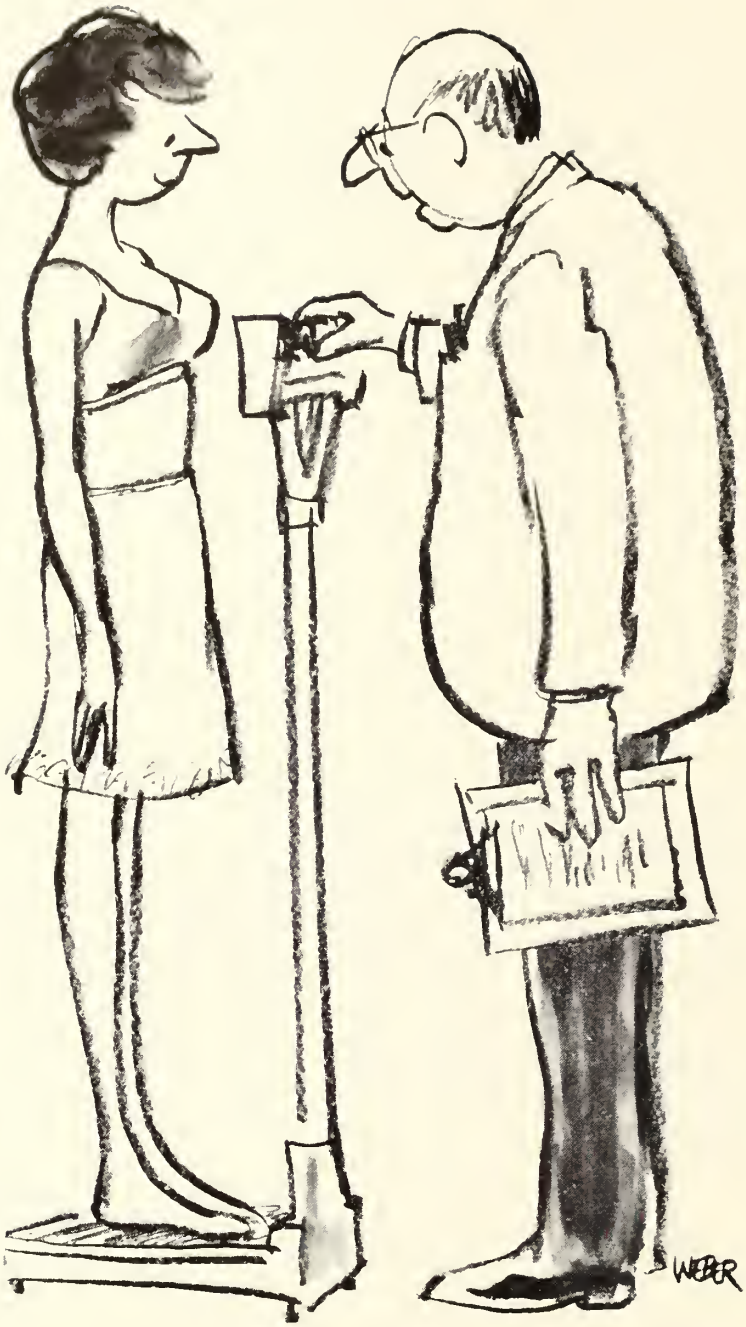
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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
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Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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affiliations, he was a member of the Catholic Church and the Catholic Physicians Guild. Survivors are his widow, two daughters, a son, and a brother.

Alexander D. Korba, M. D., Cleveland; Hahnemann Medical College of Philadelphia, 1956; aged 39; died November 2; member of the Ohio State Medical Association, the American Medical Association, and the American College of Obstetricians and Gynecologists. An earlier resident of the Cleveland area, Dr. Korba returned there to practice after serving in the Army Medical Corps from 1961 to 1963. Among survivors are his widow, a son, his parents, three sisters, and a brother. Dr. Vladamir D. Korba, also of Cleveland.

Nathan Jacob Kursban, M. D., Cincinnati; University of Cincinnati College of Medicine, 1933; aged 57; died November 19; member of the Ohio State Medical Association, the American Medical Association, the American Academy of General Practice, and the American Physicians Fellowship, Inc. A lifelong resident of Cincinnati and a practitioner there for more than 30 years, Dr. Kursban was one of the founders of the local chapter of General Practitioners. He was also a founder of the local diagnostic clinic for the mentally retarded. A member of the Temple, he is survived by his widow, a daughter, two sons, four sisters, and a brother.

Max B. Laven, M. D., Cleveland; Western Reserve University School of Medicine, 1924; aged 60; died November 5; member of the Ohio State Medical Association, the American Medical Association, and the American College of Obstetricians and Gynecologists; diplomate of the American Board of Obstetrics and Gynecology. A specialist in obstetrics and gynecology for many years in Cleveland, Dr. Laven was chief of staff at St. Ann Hospital from 1928 to 1958. He is survived by his widow, two sons, and two sisters.

Anna Jobisz Lewin, M. D., Cleveland Heights; University of Stefan Batory, Wilno, Poland, 1929; aged 59; died November 9; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Lewin and her husband, Joseph Lewin, came to this country in 1949. She practiced medicine in Cleveland from 1951 to the current year. A member of the Temple, she is survived by her husband and a son.

Earl Weldon Netherton, M. D., Cleveland; Washington University School of Medicine, 1917; aged 74; died November 1; member of the Ohio State Medical Association, the American Medical Association, American Dermatological Association, and the American Academy of Dermatology; diplomate of the American Board of Dermatology. A pioneer as specialist in dermatology, Dr. Netherton headed the Dermatology Department at the Cleveland Clinic for some 34 years, and wrote extensively in that field. In recent years he was in private practice. He was a veteran of World War I, and among affiliations, was a member of several Masonic bodies and a member of the United Church of Christ. Surviving are his widow and two sons, Dr. Thomas E. and Dr. Robert C. Netherton.

Rush Carl Newman, M. D., Spencer, W. Va.; University of Cincinnati College of Medicine, 1920; aged 78; died August 25. Dr. Newman devoted most of his professional career to practice in the Spencer vicinity.

William Haggerty Phillips, M. D., Greenville, Pa.; Western Reserve University School of Medicine, 1900; aged 92; died August 28. Records indicate that Dr. Phillips practiced for many years in the Greenville, Pa., community.

John P. Rankin, M. D., Elyria; Johns Hopkins University School of Medicine, 1918; aged 76; died November 23; member of the Ohio State Medical Association, and the American Medical Association; Fellow of the American College of Surgeons. A practitioner of many years standing in Elyria, Dr. Rankin was formerly on the faculty of Western Reserve University School of Medicine, and associated with some of the Cleveland Hospitals. He was a veteran of World War I, a member of the American Legion, the Methodist Church, the American Rose Society, and other groups.

John Henry Richardson, M. D., Columbus; Ohio State University College of Medicine, 1925; aged 76; died November 22; member of the Ohio State Medical Association and the American Medical Association. A practitioner in Columbus for many years, Dr. Richardson was former Franklin County deputy coroner, and was police and fire department surgeon for Columbus. He was a veteran of World War I and a member of the American Legion. Other affiliations include membership in several Masonic bodies, and the Christian Church. His widow, a brother, and two sisters survive.

David V. Rosenberg, M. D., Cleveland; Queens University Faculty of Medicine, 1917; aged 73; died November 24; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Rosenberg devoted virtually all of his 50-year professional career to general practice in that city. He was a veteran of World War I, having served in the Medical Corps. A member of the Temple, he is survived by his widow, two daughters, and a brother.

Frederick Auer Wolf, M. D., Cincinnati; University of Cincinnati College of Medicine, 1950; aged 45; died in airliner crash November 20; member of

(Continued on Page 119)

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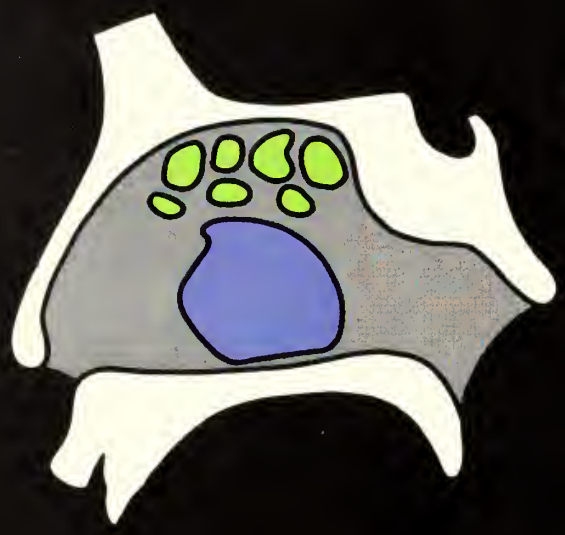
Sources of sinus headache





REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.





MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.





TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

the Ohio State Medical Association. A native of Cincinnati, Dr. Wolf served in the Armed Forces during World War II, and entered practice in 1950 after completing his medical training. His specialty was industrial medicine and he was associated with the Queensgate Medical Center. Among activities, he was a member of the OSMA Committee on Workmen's Compensation. At latest report, his wife, also a victim of the same accident, was hospitalized in Cincinnati. Others in the family are three sons and two daughters, his mother, a sister, and a brother, Dr. Robert A. Wolf, of Pasadena, Calif.

Need Volunteer Physicians to Man Eye Clinic in Vietnam

More than a year ago volunteer American physicians launched a new battle in South Vietnam — against eye disease. At the request of the Vietnam government, an ophthalmology program was started at Vinh Long Provincial Hospital in the Delta, south of Saigon.

The first volunteer was W. Conrad Stone, M. D., Roanoke, Va. who started organizing the program in October 1966. The need for major eye treatment had been underscored by a U.S. military medical team that discovered extensive eye disease in the Delta.

Dr. Stone spent two months in Vietnam under the auspices of the American Medical Association Volunteer Physicians for Vietnam program. He was scheduled to return in January.

But more volunteers are essential to keep the program advancing. Charles H. Moseley, M.D., director of the AMA volunteer program, said 12 ophthalmologists are needed in 1968 in order to maintain two in Vietnam at all times.

People are seeing now who never saw before as a result of the eye program, Dr. Moseley said. Many cataracts have been removed and children who needed glasses are getting them he added, and the Vietnamese people have enthusiastically embraced the program.

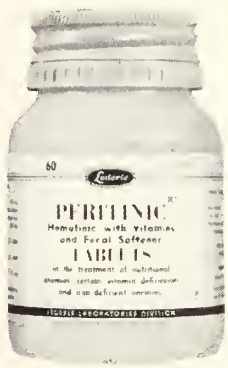
The eye program, Dr. Moseley explained, is designed to provide care, preventive medicine, an improvement in the administration of the Vinh Long Ophthalmology Service, and teaching of Vietnamese medical students.

Physicians interested in the eye program can write to Dr. Moseley at the AMA, 535 N. Dearborn St., Chicago, Illinois 60610.

More than five million veterans visit Veterans Administration outpatient clinics in a year, VA reported.

The Veterans Administration reports that it is guardian to approximately 650,000 incompetent veterans, incompetent dependents, and minor children. Their estates amount to almost $700 million.

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Activities of County Societies

CRAWFORD

A veteran Crawford County physician who has chalked up 50 years in service to his fellow men was honored for that half century at a meeting of the Crawford County Medical Society held at the Chateau de Charme Tuesday evening (Oct. 31).

He is Dr. Karl Herman Barth, 76, of New Washington, who received a lapel pin and plaque from the society.

Making the presentation to Dr. Barth was Dr. Frederick Merchant of Marion, Councilor of the Third District of the Ohio State Medical Association.

Among those present for the ceremony was Dr. Barth's son, Dr. James Barth, and Dr. Tom Huggins of Galion, who was delivered by the elder Dr. Barth.

Dr. Barth, born in Chatfield Township June 8, 1891, was educated in the Chatfield schools, graduating there in 1909. He taught for three years in area one-room schools and then attended medical preparatory school at Ohio Northern University.—*Bucyrus Telegraph-Forum.*

FRANKLIN

Dr. H. William Porterfield takes office as president of the Academy of Medicine of Columbus and Franklin County on January 1, succeeding Dr. Tom F. Lewis. Dr. Ben E. Jacoby was named president-elect, and Dr. Keith DeVoe, Jr., was named secretary-treasurer.

For the November 21 meeting, the program was conducted by three specialty societies—the Neuropsychiatric Society of Central Ohio, Central Ohio Academy of General Practice, and the Columbus Society of Anesthesiologists. This was a dinner-meeting at the Neil House Hotel.

Effective October 1, a new information service was started as a service to physicians in regard to their patients who need extended care facilities. This is a cooperative venture by Nationwide Mutual Insurance Company, Columbus Bureau of Medical Economics, and the Academy of Medicine of Columbus and Franklin County.

The listing started with 12 approved extended care facilities for Medicare patients, with not many vacancies existing in these facilities. Nationwide will provide current information to the Medical Bureau switchboard on facilities which have vacancies and this information will be made available to physicians.

HAMILTON

Dr. Milford O. Rouse, Dallas, Texas, President of the American Medical Association, was guest speaker for the November 21 meeting of the Academy of Medicine of Cincinnati. His topic was, "The Case for the American Medical Association."

LORAIN

A good attendance at the November 14 meeting of Lorain County Medical Society was indicative of the members' interest in a panel program presented by local physicians.

The following members of the Society represented the various specialties involved in "Traumatic Surgery"—the theme of the panel discussion: Charles Butrey, M.D.—general practice; Gerold Brugger, M.D.—neurological surgery; Peter J. Ferrato, M.D.



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—thoracic and cardiovascular; Delbert L. Fischer, M.D.—orthopedic surgery; and William H. Miller, M.D.—general surgery and urology. J. A. Cicerrella, M.D., acted as moderator and the audience stimulated an interesting question and answer period following the presentation.

Vice-President, D. E. Harrison, M.D. conducted a short business meeting prior to the program and the Nominating Committee Report of the 1968 Slate of Officers was presented by Chairman J. A. Cicerrella, M.D.

Edward M. Lees, M.D., of Elyria, and Joseph R. Novello, M.D., of Lorain, were elected to Associate Membership in the Society.

* * *

A record attendance marked the Annual Meeting of Lorain County Medical Society, when members and wives met at Oberlin Inn on Tuesday evening, December 12.

Installation of officers for 1968 was preceded by a social hour and dinner. Delbert L. Fischer, M. D., of Lorain, will assume the responsibilities of president on January 1. President-elect will be Maynard J. Brucker, M. D., of Amherst; Irwin M. Suna, M. D., of Elyria, was installed as vice-president, and H. B. Rosenbaum, M. D., of Lorain, as censor for a 3-year term. John B. McCoy, M. D., of Elyria, was re-elected for a 2-year term as secretary-treasurer, as were Ben V. Myers, M. D., of Elyria, and James T. Stephens, M. D., of Oberlin, as delegates to Ohio State Medical Association. The alternate delegates Max L. Durfee, M. D., of Oberlin, and William H. Miller, M. D., of Elyria, were also re-elected. Two censors presently in office — Charles Butrey, M. D., of Lorain, and William L. Hassler, M. D., of Elyria, will continue their term of office until December 1968 and 1969 respectively.

The new president graduated from Western Reserve University, and has practiced as an orthopedic surgeon in Lorain since 1956. He served in the Navy from 1952 through 1954 and was with the First Marine Division in Korea. He is actively concerned with the Rehabilitation Center of Lorain County, and has served on the Board of Directors of that organization.

OSMA 50-Year Certificates and Gold Emblems were presented to two physicians by William R. Schultz, M. D., Councilor of the 11th District, who with Mrs. Schultz were guests of the Society on that evening. I. C. Riggin, M. D., of Lorain, and Aaron Smith, M. D., of Amherst, were the recipients, and short biographical sketches on their achievements were given by M. Kolczun, M. D., of Lorain, and G. Wiseman, M. D., of Amherst.

An auction sale sponsored by members of the Women's Auxiliary was the highlight of the evening following the business meeting. Mrs. Maynard Brucker, President, acknowledged the time and effort afforded to this project by physicians and their wives who made and donated the objects for sale. Proceeds are earmarked for the furnishing of a Clinic at the Lorain County School for the Retarded. A total of approximately $700 was collected.

MAHONING

Nomination of officers was part of the business transacted during the November 21 meeting of the Mahoning County Medical Society. A social hour and buffet dinner preceded the meeting.

Among programs sponsored in the community was Diabetes Week, November 12-18, sponsored by the Medical Society and the American Diabetes Association.

ROSS

The Ross County Academy of Medicine paid tribute to Dr. Edwin H. Artman, Chillicothe, at the December 7 meeting, for long and dedicated service of leadership in the medical profession.

It was 20 years ago that he was named President-Elect of the Ross County Academy of Medicine, and subsequently served as its President. He has filled numerous other offices in the local Society; has served as Councilor of the Tenth District to the Ohio State Medical Association, as President of the State Association, and as Alternate Delegate and Delegate to the American Medical Association. This year he completed 15 years as a member of the Ohio Delegation to the AMA.

As a long confrere in organized medicine, Dr. Richard L. Meiling, Columbus, was invited to make a special presentation to Dr. Artman in behalf of the Society. He presented a beautiful silver tray, suitably engraved. Dr. Meiling is a Past President of the Ohio State Medical Association, Delegate to the AMA, and Dean of the Ohio State University College of Medicine.

TRUMBULL

Featured speaker for the November 15 meeting at the Trumbull Country Club was Dr. Tim Lee Carter, Republican Congressman from Kentucky. The Tompkinsville physician and congressman is a member of the Armed Forces Committee and has made several official trips to Vietnam.

The November Society newsletter contained an appeal for contributions to the American Medical Association Education and Research Foundation (AMA-ERF), and explained in some detail functions of the fund. Dr. Densmore Thomas, is chairman of the AMA-ERF committee for the Society, and Mrs. Jerome J. Stanislaw, chairman for the Auxiliary, with Mrs. Helen Casale, cochairman.

Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

A NEW YEAR — a New Look — a New Resolve — a New Auxiliary Sense. This reporter has no wish to use this column as a pulpit and to come forth with a sermon. What she does believe, however, is that this column is an important means of communication and that such communication should, at times, "jog" the membership into renewed awareness and enthusiasm.

Is there a better time than this to do just that — at the beginning of this New Year of 1968? Remember the time-honored tradition of making New Year's Resolutions? You don't hear too much about that, any more. Perhaps too much fun was poked at them. Yet the making of sensible, pertinent resolutions is not a fun game, or something without merit. It is a step in the right direction — that by "resolving" to do thus and so, we are conscious of our shortcomings and are, at least, making an effort to do something about them.

I don't know of anything which perplexes this writer more than to hear a doctor's wife say "I'm in too many organizations already to be able to give time to Auxiliary work." I recall our State President, Mrs. J. Paul Sauvageot, saying not too long ago "we should not have to beg for members; it should be a privilege to be a member." How true! Certainly there is no quarrel about giving time and effort to other community projects. That's as it should be. But to use those other efforts as an excuse for not meeting their obligations as doctors' wives is something else again. For every doctor's wife, whether she is willing to admit it or not, DOES have an obligation to the medical profession. Certainly it must be apparent that Auxiliaries serve a remarkably useful purpose — Dr. Milford O. Rouse, AMA President, wants and hopes that the national auxiliary membership will pass the 100,000 mark — 10,000 more than we now have. He has even gone a step further, with a "matching plan," promising that the AMA will try to enlist 5,000 new auxiliarians if we will do the same. (You can be sure that Mrs. Karl Ritter, National President, has taken up the challenge!)

Mrs. Ritter commented recently that "new members are the result of person-to-person contacts, not brochures or leaflets." She said further that there must be well-informed, enthusiastic leadership locally, for the local level is the starting point and the sustaining point! Mrs. Howard Liljestrand, national first vice-president and membership chairman, has come up with what she calls "Operation Adoption — a four-step program: 1) With the help of your medical society, make a list of all prospective members; 2) Invite each auxiliary member to pick a person from the list to "adopt" for three months or six months or even a year — as long as it takes to interest her in the auxiliary; 3) Give the "adoptee" the so-called sorority rush — escort her to meetings, give her copies of MD's Wife, invite her and her husband to your home, clue her in about current auxiliary activities and projects; and 4) Take her to a membership coffee held by your auxiliary for prospective members; pull out all the stops and make her feel at home.

"Operation Adoption" does not have to be limited to new members. It can work equally well with women already members who do no more than pay dues and seemingly couldn't care less about really participating in auxiliary work. Give them the New

(Continued on Page 126)

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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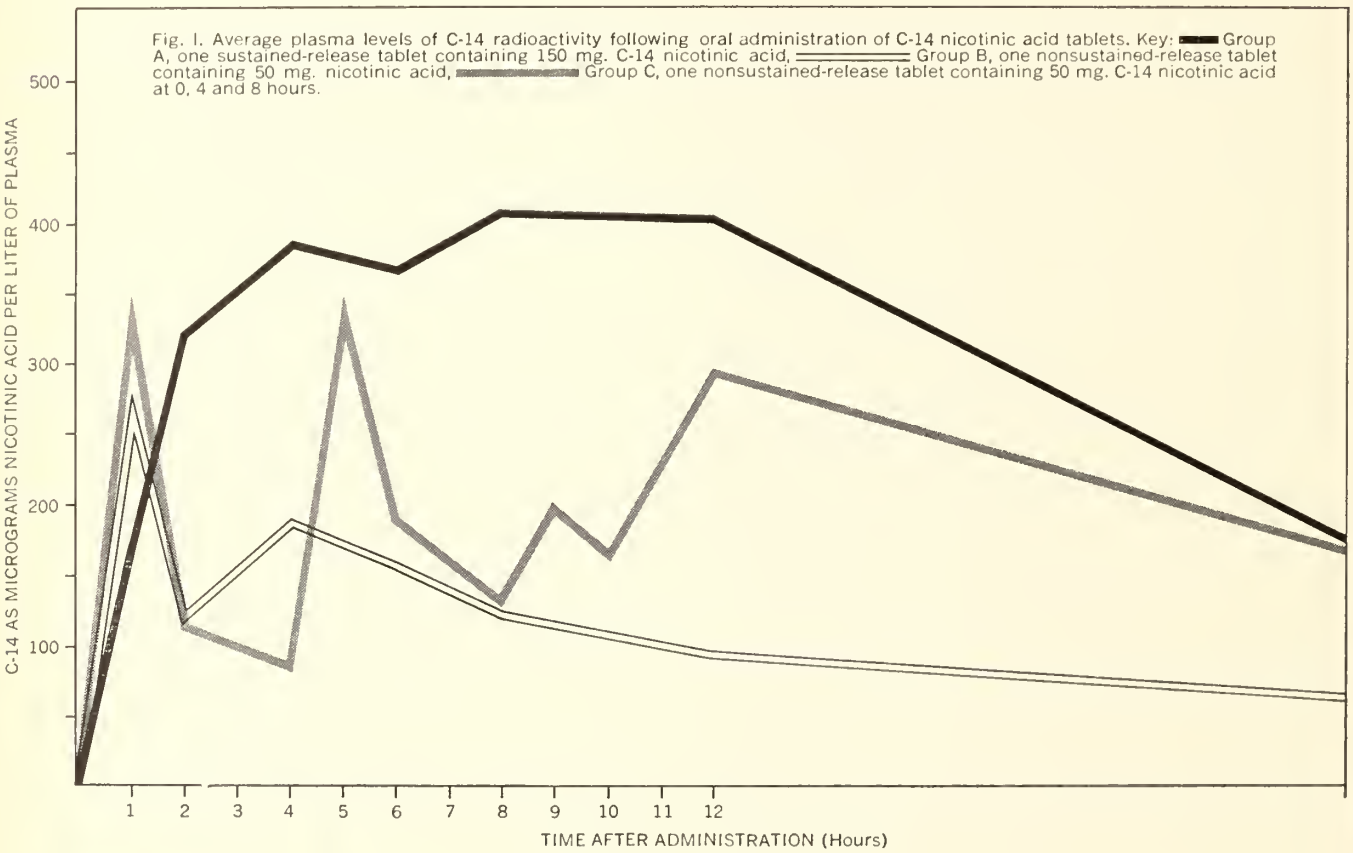
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(fewer absent doses by absent-minded patients)

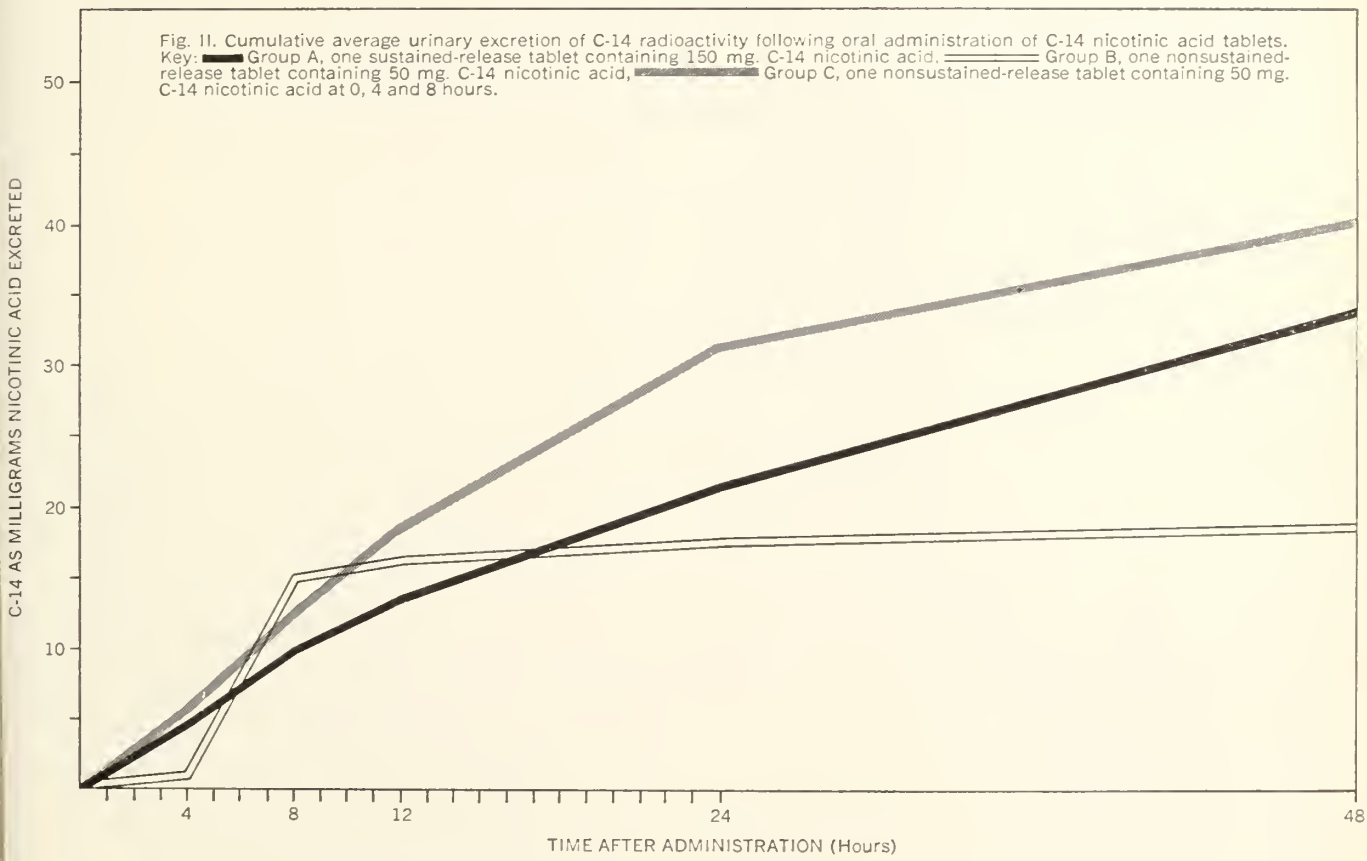
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

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Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

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less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

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Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Look — urge them to make a New Resolve — inspire in them a New Auxiliary Sense. It CAN be done. How about making that YOUR New Year's resolution?

Here and There

The October meeting of the **Allen County** auxiliary was a luncheon affair as guests of the Sisters of St. Rita's Hospital. Sister Mary Caroline, hospital administrator, invited members to tour the new facilities. Mrs. L. W. Like, auxiliary president, outlined projects for the year with emphasis on a venereal disease education program aimed at the teen-ager. A musical program was provided by Mrs. William Grannis, vocalist, and Mrs. Henry Hollinger, pianist. New members welcomed were Mrs. John Park, Mrs. James Chung and Mrs. Eduardo Guernica.

Guest speaker for the group's November luncheon meeting was Mrs. S. L. Meltzer, author of a recently published novel, and state publicity chairman. (This is rough writing about oneself!) She discussed the dramatic, and almost unbelievable early days of the x-ray as well as the poignant laryngectomee story. The luncheon was held at the Lost Creek Country Club. Mrs. Karl Ritter introduced the speaker.

The November meeting of the **Allen County** group featured the delightful Mrs. Frank Gastineau of Indiana, a former past national president. Mrs. Gastineau who is the only woman on the board of AMPAC, spoke on "The Doctor's Wife in Political Action." She pointed out that there are more eligible women voters than men and more women in political parties. "Women, therefore," she said, "have a great responsibility in deciding issues that range from the local school boards to the Presidency of the United States."

Members of the November committee meeting included: Mrs. F. Miles Flickinger, chairman; Mrs. Carl Zinsmeister, Mrs. Harold Stelzer, Mrs. K. O. Pajor, Mrs. James McBride, Mrs. John Tillotson and Mrs. David Neilson. Hostesses for the October meeting were: Mrs. A. V. Armbruster, chairman; Mrs. John Glorioso, Mrs. Ralph Snowball, Mrs. Frederick Maurer, Jr., Mrs. Gerald Deehan and Mrs. Herbert Bell.

Touch of Camelot

There were the flourish of trumpets and the bows of pages as some 350 couples swept into the Statler Hilton Ballroom on a memorable night in November in Cleveland. It was **Cuyahoga County's** Chrysanthemum Ball Royale, and it really was something special. While the formal ball is traditional, the theme was new, according to cochairmen, Mrs. Michael A. Klema and Mrs. Norbert S. Gizinski, and they admitted freely the influence of the popular play and movie, "Camelot."

It was Medieval Pageantry at its best, from the gold-enveloped red-sealed prizes to the gold tablecloths with red velvet bands and lantern centerpieces — every phase rich in heraldic tapestry. Dr. Charles Higley was a dignified and regal King Arthur. Dr. Jerome Litt was a highly entertaining Sir Lancelot. "King Arthur" was duly crowned midst trumpet fanfare and martial music. "Sir Lancelot" was fittingly armour-clad. Other members of royalty included Mrs. Litt as Guinevere, Dr. Elden C. Weckesser as Grand Knight (he's county medical president) and Mrs. Reuben R. Gould as Grand Lady (she's Cuyahoga auxiliary president). It was all an elegant romantic spectacle — soft lights and sweet music — every doctor a veritable Knight, every doctor's wife a Lovely Lady of the Court.

Here's a rather delightful quote from Cuyahoga's Newsletter, "Back Seat": "Now that the feasts of Thanksgiving, Christmas, and Twelfth Night are over, you may want to take the advice of Hippocrates, the Father of Medicine. He claimed that 'fat people

(Continued on Page 131)

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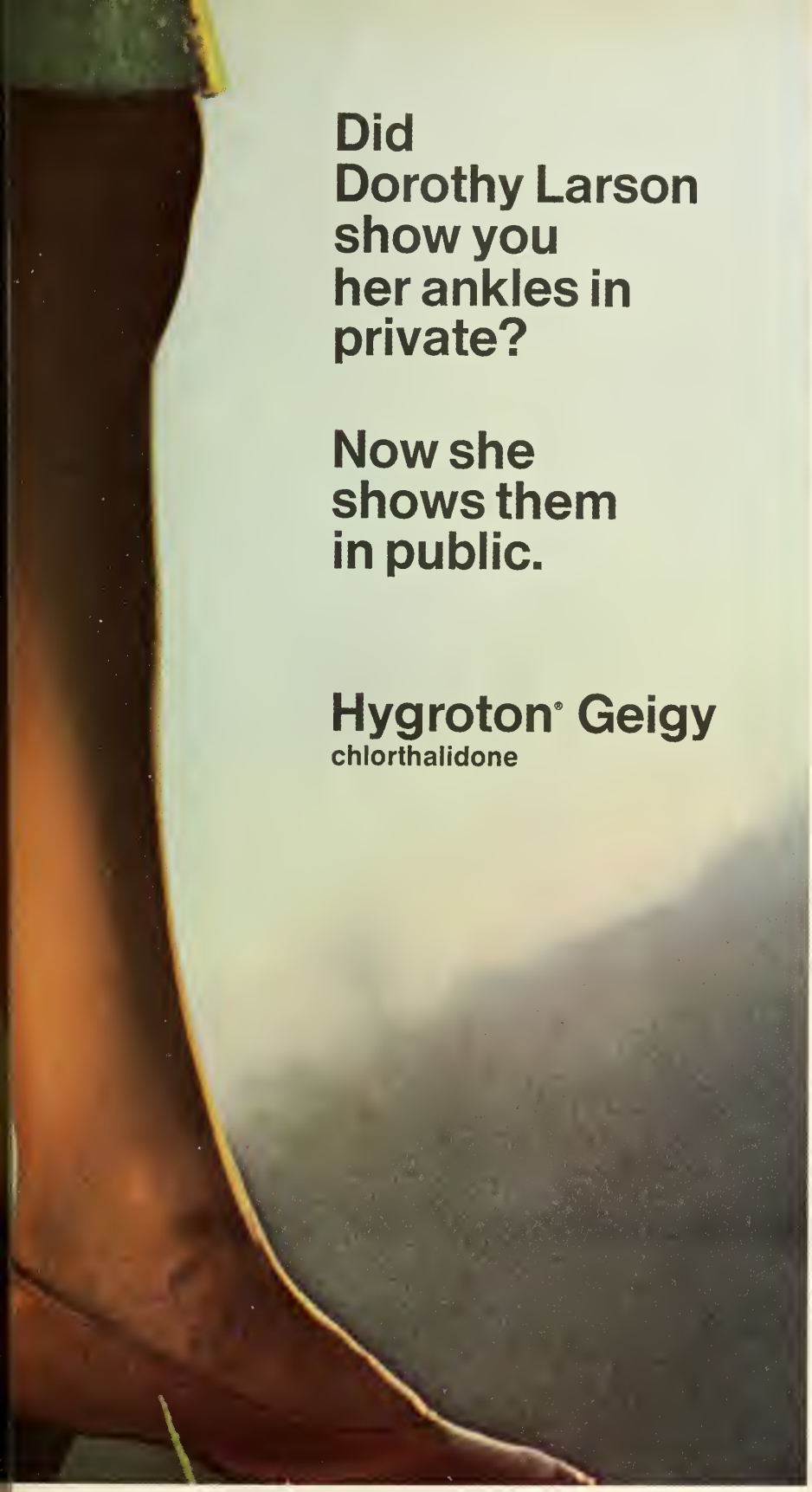
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cause of the possibility of pro
sion of renal damage, periodic
determination of the BUN is in
cated. Discontinue if the BUN r
or liver dysfunction is aggravat
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does not have marked oli-

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ischemic heart disease and
ents receiving corticoste-
ACTH, or digitalis. Salt re-
n is not recommended.
e Reactions: Nausea, gastric
on, vomiting, anorexia, con-
on and cramping, dizziness,
ess, restlessness, hyperglyc-
hyperuricemia, headache,
cramps, orthostatic hypo-
tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
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who want to reduce should take exercise on an empty stomach and sit down to the table while out of breath.' The idea? Exhausted people don't overeat!"

A recent luncheon meeting of the **Columbiana County** auxiliary featured, as guest speaker, Mrs. Edith Martsolf of the Columbiana County School for Retarded Children. She described the growth of the school over the years and discussed the reasons for her enthusiasm in the future Robert Bycroft School. Mrs. K. S. Ulicny, president, conducted the business session. Letters of appreciation were read from Alberta Johnson and Karen Eckart, recipients of the Health and Medical Careers Scholarship Loans. The highlights of the afternoon was an "international bazaar," featuring items brought by auxiliary members (many of them handmade) and sold for the benefit of the retarded children's school. A profit of $125 was realized — a nice, tidy sum, I might add! Co-hostesses for this meeting at the Salem Golf Club were Mrs. Lee Bookwalter and Mrs. Ralph Vance.

A very recent edition of **Franklin County's** "News Release" was devoted to International Health. It listed the kind of drugs, equipment, and material needed for World Medical Relief. It gave specific instructions on how to prepare Knitted Leper Bandages, Lap Robes, Afghans, Knitted Caps for Girls and Boys, etc. Mrs. A. L. Kefauver is chairman of the committee. "TV Narcosis, Good Thing or Bad" was the topic discussed at the group's recent luncheon meeting at the Jai Lai by Richard Mall, Ph. D. Dr. Mall, a former professor of speech at Ohio State, is now executive secretary of the OSU Alumni Association. Did you know that the Franklin County Group can boast of a Glee Club? (I have heard these gals and they're terrific!)

"Dance for Health"

The **Hamilton County** auxiliary is another group that features an annual dinner dance to help support its many projects. This year's proceeds are designed for Nursing Scholarships, operation of the Apple Tree, contributions a la AMA-ERF for Cincinnati's College of Medicine and the practical nursing program at Courter Technical High School. The traditional dance was held in December at the Hotel Sheraton-Gibson. Mrs. Curwood R. Hunter as general chairman, with Mrs. Jose G. Ibanez as co-chairman. Other committee members included: Mrs. Richard Wendel, Mrs. John L. Thinner, Jr., Mrs. Gerald Castle, Mrs. Noble O. Fowler, Mrs. Fernard R. Siegel, Mrs. Joseph F. Wright, Mrs. Emil L. Barrows, Mrs. Edward J. Bender, Mrs. Herman J. Nimitz, Mrs. Denis F. Cash, Mrs. Robert E. Krone, Mrs. Elliott Hilsinger, Mrs. Joseph Podesta, and Mrs. William Thornell. "Toyland" was the theme of this social event which sounds most intriguing (wish I had the details to pass on!).

The Hamilton group's November luncheon meeting featured a special film "Highlights of the Ancient Middle East" which was made from photographs taken by Dr. and Mrs. William C. Schmidter on a recent Medi-Club flight to that area of the world. The interesting and informative movie was shown with a dubbed-in sound track. Luncheon hostesses were Mrs. N. G. Amato and Mrs. Lawrence J. Gibboney. Gift items and Christmas cards were on sale at a boutique for the benefit of AMA-ERF. (An aside: This auxiliary gave "its all" in promoting the sale of Christmas cards, holding informal coffees for friends and neighbors and doing a superb job of salesmanship . . . I know many other auxiliaries who do a terrific job too, but I don't have the specific information to detail here.)

From **Lucas County** auxiliary comes word of its November Guest Tea at which Miss Helen Manley discussed the need for sex education for children in kindergarten and through high school. "All children inevitably learn about sex," she said. "Having it taught in the schools would insure their acquiring the knowledge authoritatively and in a manner consistent with their ages." Medical Supplies' Days for World Medical Relief were Friday and Saturday, November 10 and 11. Transported to Detroit for distribution by World Medical Relief were: 100 cartons of drugs, two examining tables, scales, innumerable surgical instruments, a BMR machine, sterilizer and many other pieces of equipment donated by the doctors and area pharmacists. "Gone With the Wind" had a very special opening night in Toledo on November 15. It was the local group's unusual effort for benefit of Project Hope.

"Blend Well"

Take a group of doctors' wives. Add a group of lawyers' wives. Season with politics and blend well. And you have a mighty important get-together. That's what the **Montgomery County** auxiliary did, choosing as the theme of this meeting "What Every Woman Should Know About Politics," under the chairmanship of Mrs. Sylvan Weinberg, a past president of the group. Co-chairman was Mrs. Austin Hammond who had decked the Sheraton ballroom with provocative signs (a sample — "Your Vote: Mystique or Mistake?") Mrs. Clara Weisenborn, State Senator, commented that "during the last four years, women have lost over 200 seats in state legislatures . . . we have fewer women in government than any country in the world." She stressed the need for more "Woman Power." Fred Young and Harry Imbys discussed the anatomy of political parties. Charles Ross and Judge Carl Kessler told about the intricacies of running a campaign. Mrs. Harry L. Fry, state vice-president and former state legislative chairman, spoke on political issues.

HAPPY NEW YEAR!

I don't know who authored these words, but they say so much so briefly: "Thine own wish, wish we thee."

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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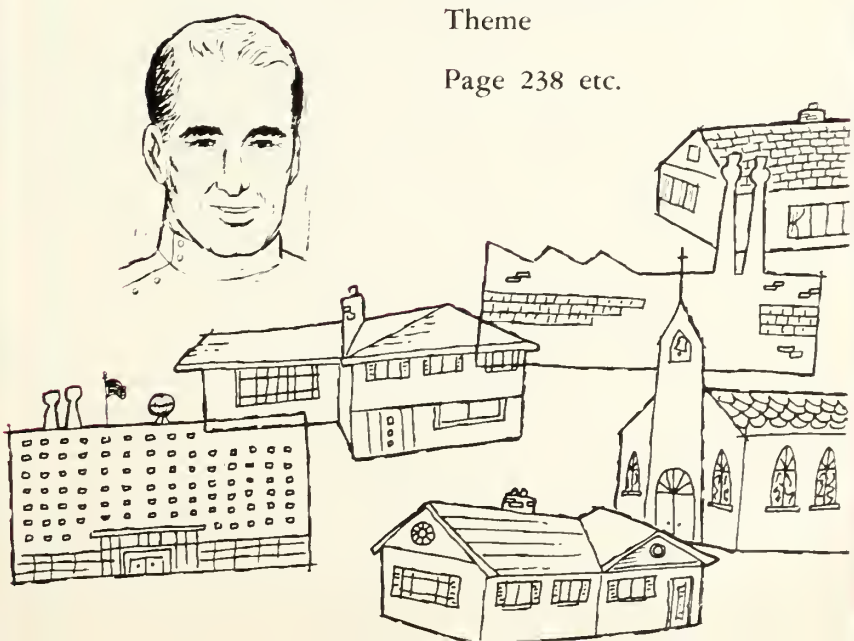
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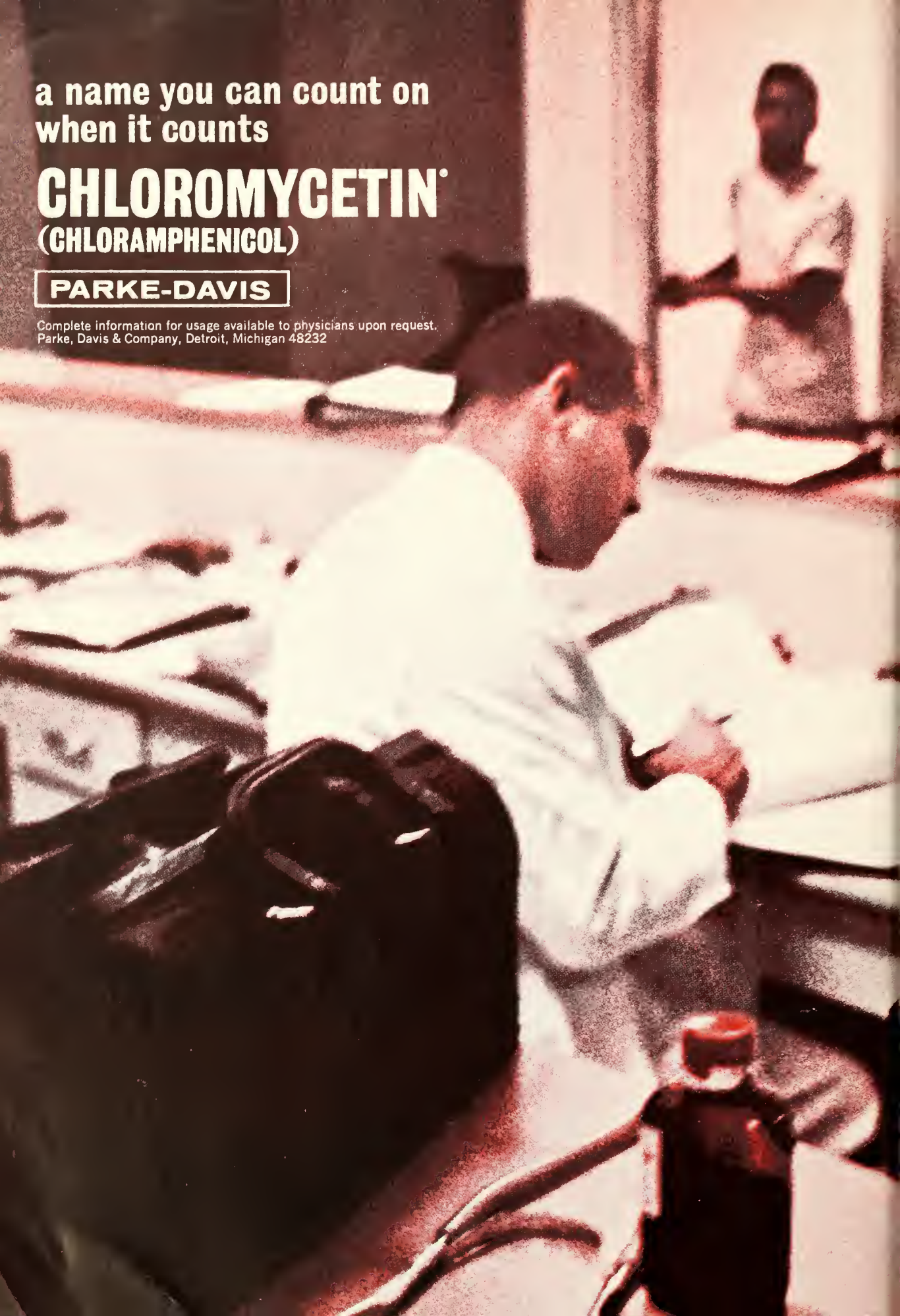
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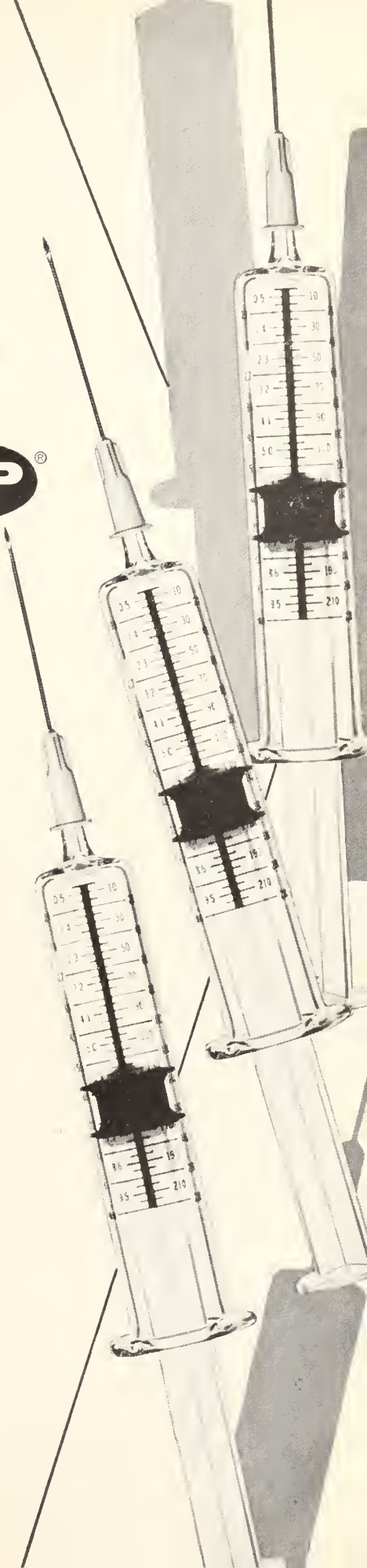
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Address All Correspondence:
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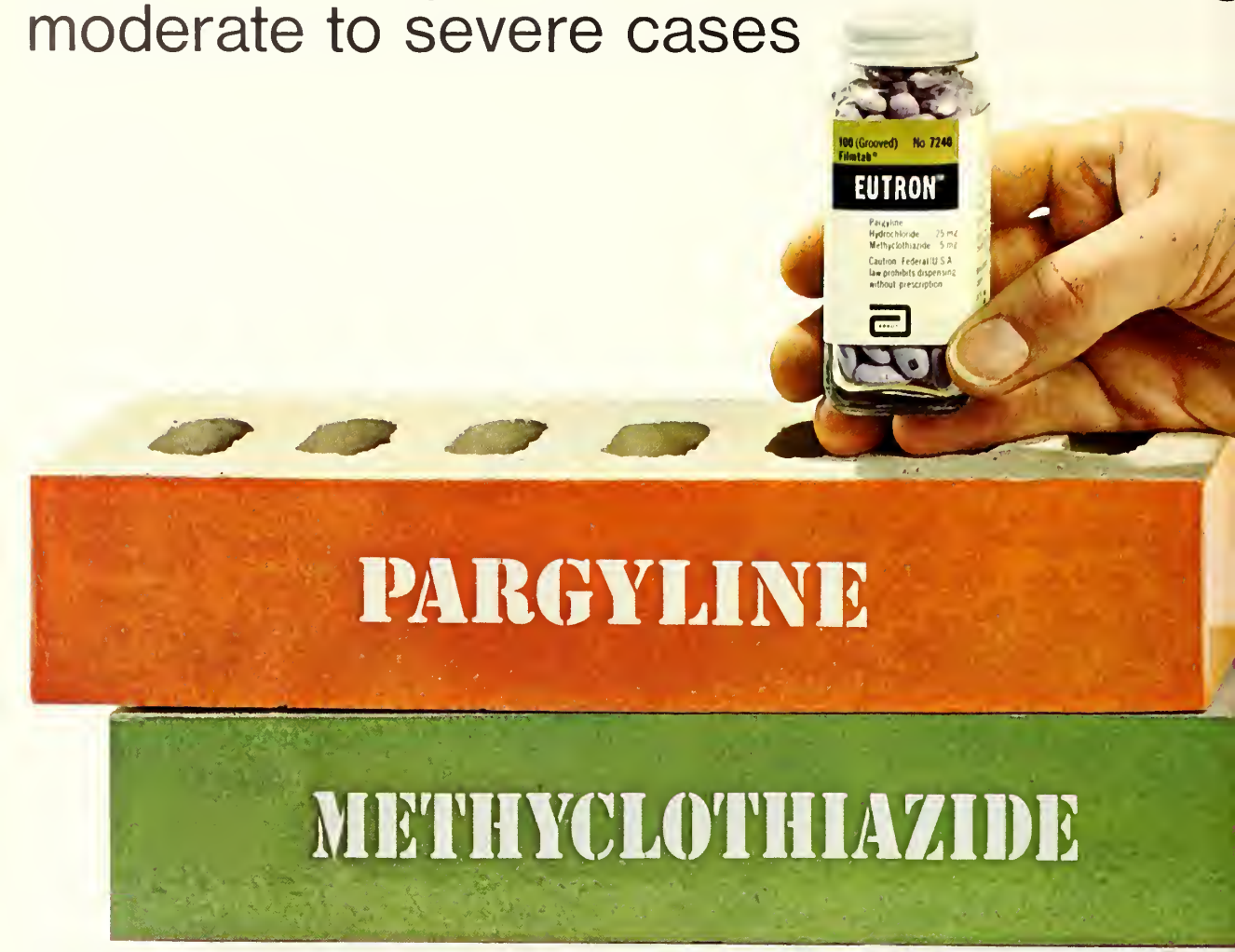
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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

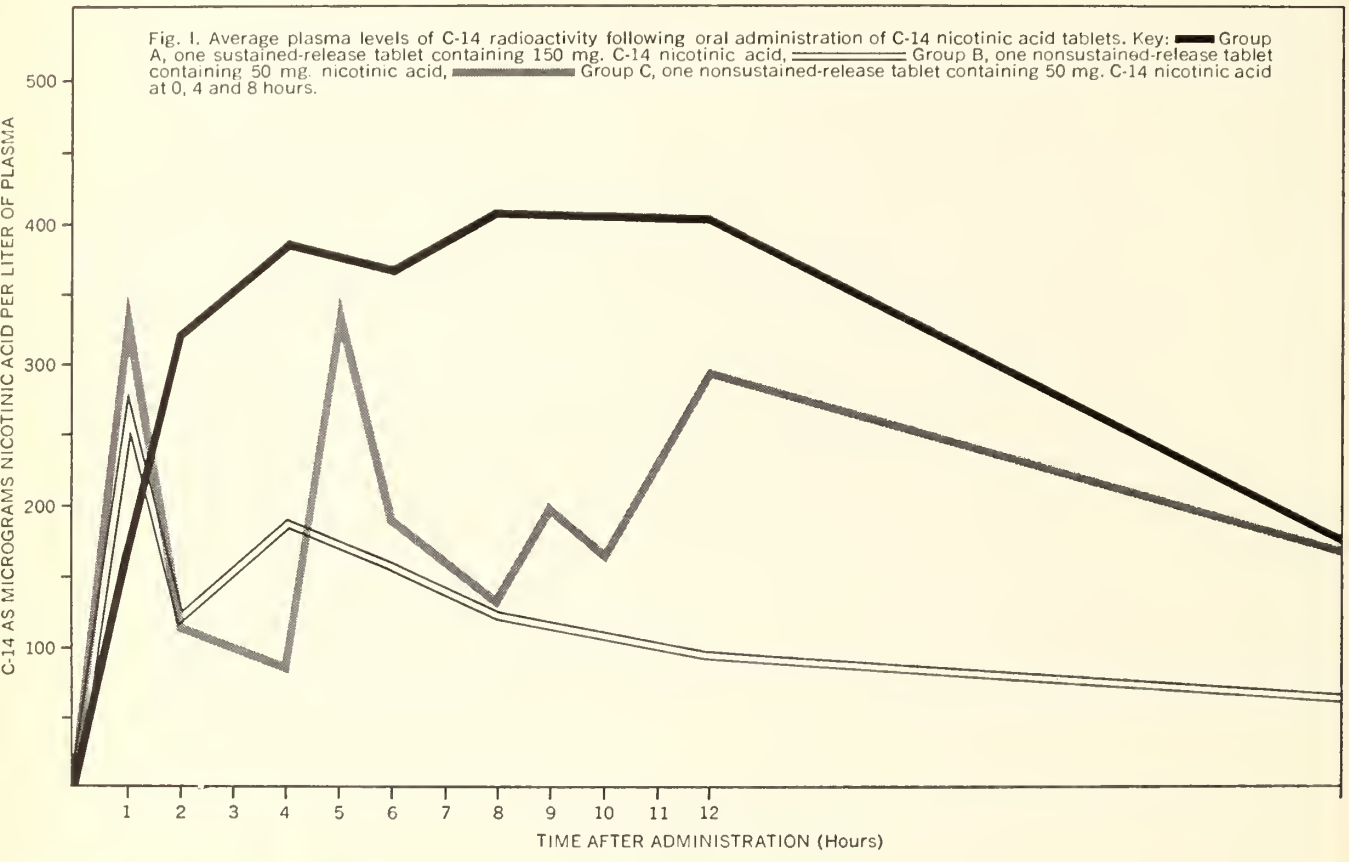
During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

801438

ABBOTT

Sustained circulatory, respiratory and cerebral stimulation for the





(fewer absent doses by absent-minded patients)

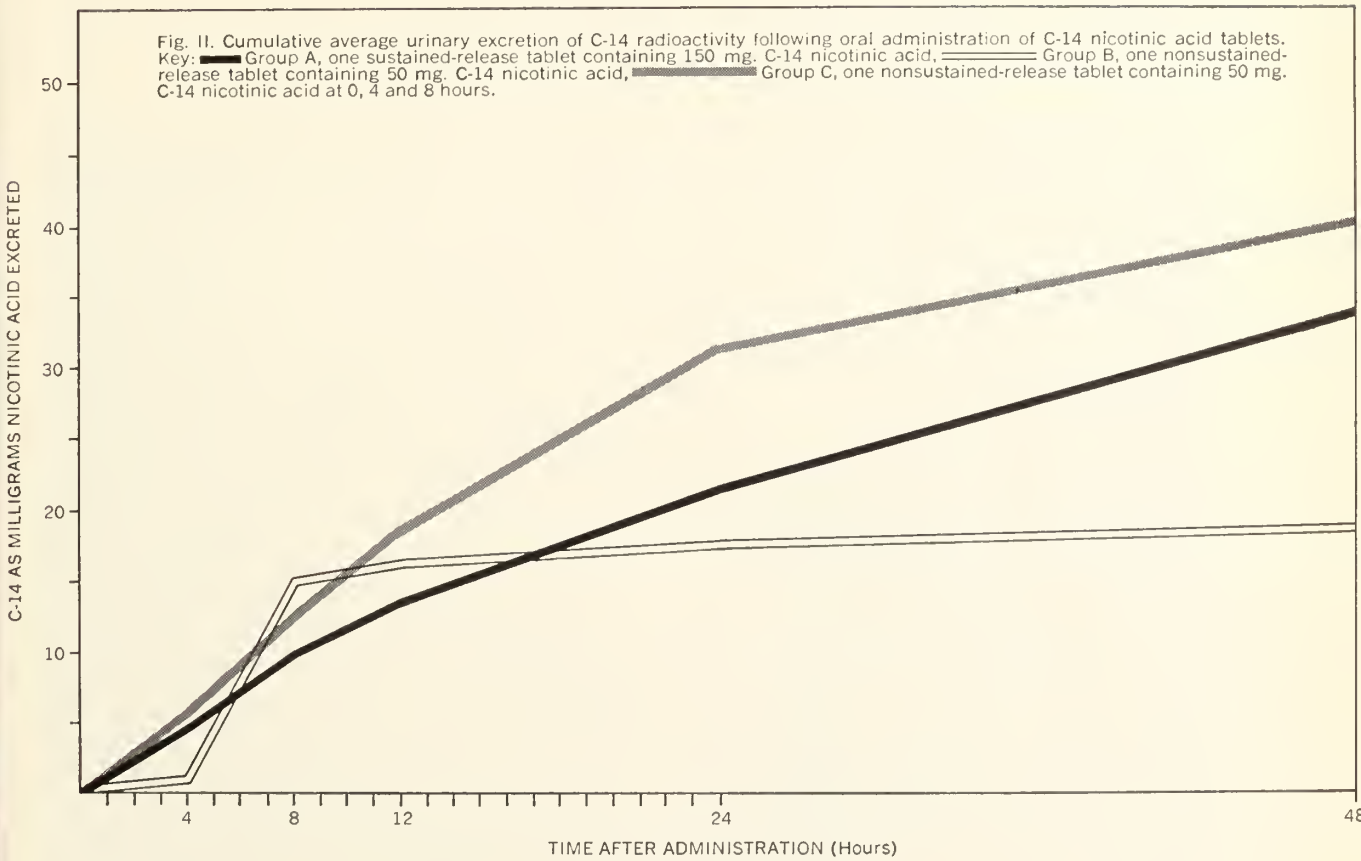
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ıged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT
nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet



Zollinger-Ellison Syndrome Grant Furthered by Hartford Grant

Research on the relationships between tumors of the pancreas and peptic ulcers is being expanded at the Ohio State University College of Medicine under a $250,000 research grant from the John A. Hartford Foundation, Inc., New York City. The studies are directed by Dr. Robert M. Zollinger, professor of surgery and chairman of the Department of Surgery.

Since 1955, when Dr. Zollinger and his associate, Dr. Edwin H. Ellison, first described the ulcerogenic tumor syndrome, a hormone similar to gastrin has been isolated from the tumors.

Recent evidence has suggested that a second, "diarrheogenic," hormone is caused or produced by the tumor. The team headed by Dr. Zollinger will further research this area, and investigate drugs and vaccines which may inhibit the activity of these hormones.

The new grant also will enable Dr. Zollinger and his associates to provide expanded diagnostic and treatment services to patients suspected of harboring ulcerogenic tumors of the pancreas. The Lai rat bioassay test, named for Dr. K. S. Lai of The University of Edinburgh, is one of the newer diagnostic methods which will be used at Ohio State for determining the presence of these tumors by detecting over-secretion of gastric juice.

The Lai rat bioassay is offered by the Department of Surgery as a diagnostic service to physicians all over America and in foreign countries. When physicians suspect that a patient has peptic ulcer disease caused by a pancreatic tumor (the Zollinger-Ellison Syndrome), they can send blood or urine specimens to Ohio State for bioassay. The Hartford Foundation grant will allow expansion of this service.

Drug Abuse by Young People Will Be Chicago Program Theme

A two-day conference for physicians on the abuse of drugs by young people will be sponsored by the Council on Mental Health of the American Medical Association March 15 and 16 at the Drake Hotel in Chicago.

The program will include discussions of the causes of drug abuse, the treatment and rehabilitation of drug dependent persons, deterrents to drug abuse and latest research findings in the field. A highlight of the conference will be a panel presentation on medical management of those who abuse drugs and become dependent on them.

Other physicians interested in attending may write to the Department of Mental Health, American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610 for complete program details and registration information. There is no registration fee.

winter 1968

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.





this issue: the cold in pregnancy...

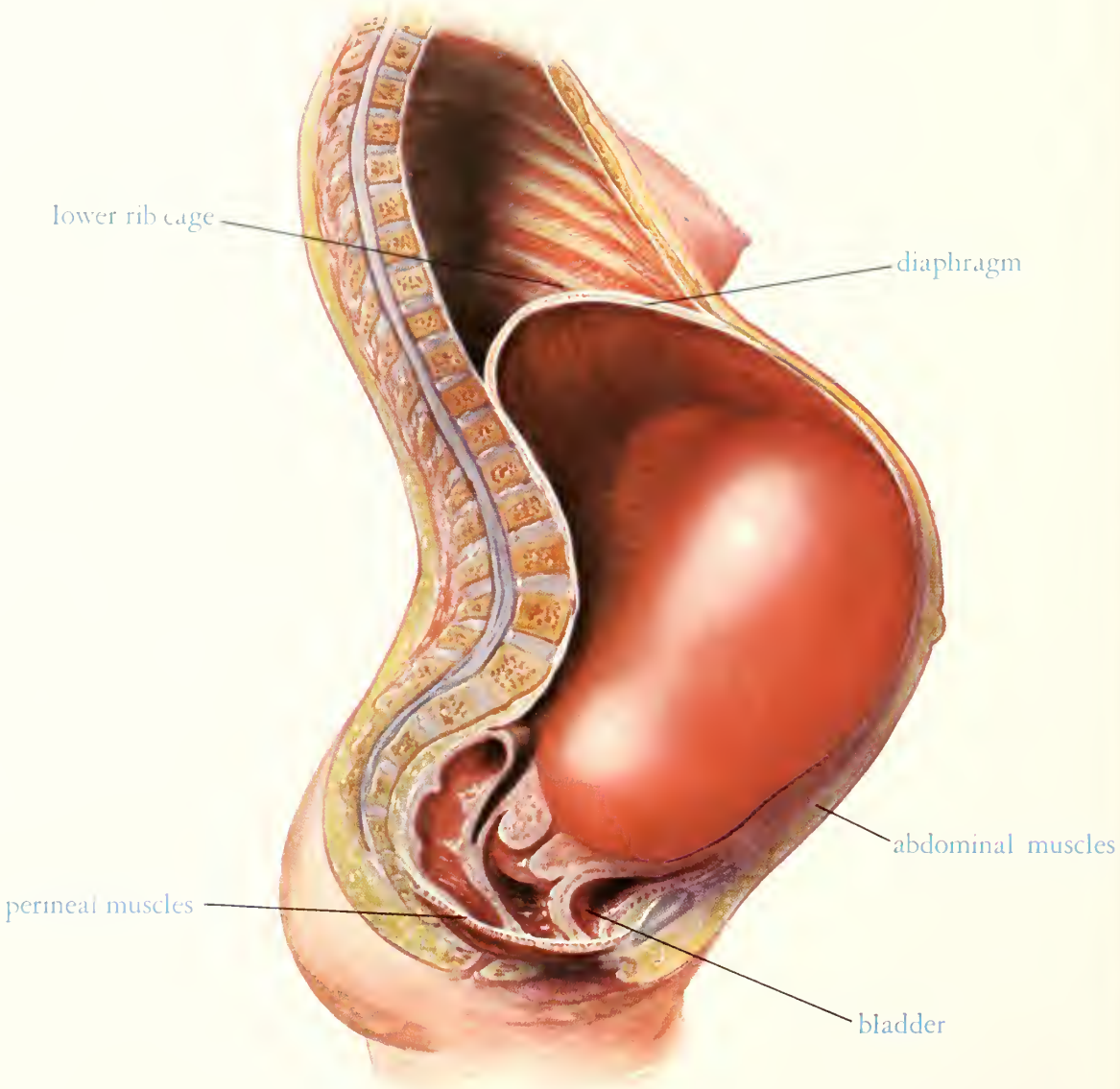
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



on. Kiesselbach's area in the nose (on the anterior art of the nasal septum above the intermaxillary one) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

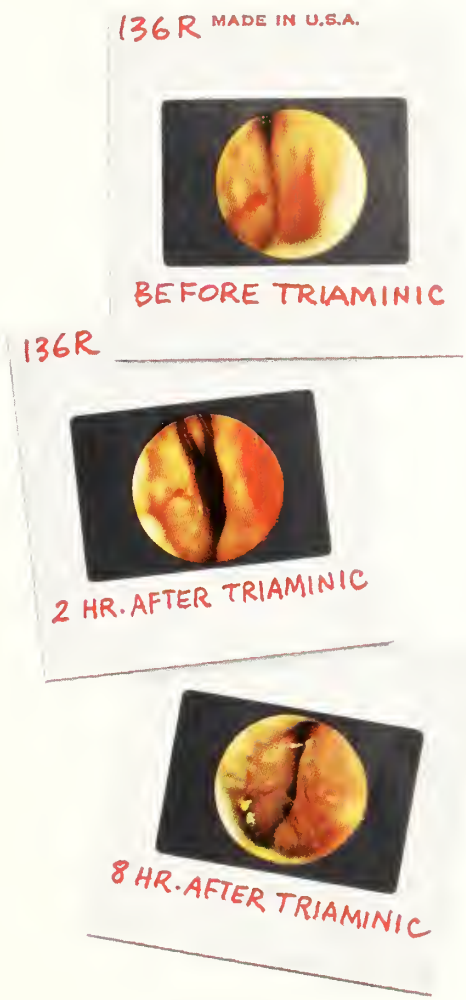
s well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

From a continuing study on nasal congestion...



timed to work while your patient does

A study begun in 1966 by the Department of Otolaryngology, Greater Baltimore Medical Center, has accumulated evidence that documents the effectiveness of Triaminic's timed-release action in the treatment of nasal congestion.

With its balanced formulation of an oral nasal decongestant and two antihistamines, Triaminic effected partial or complete relief in more than 82% of the 85 subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic really works.

Triaminic® *timed-release tablets*

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50mg.
Pyrilamine maleate	25mg.
Pheniramine maleate	25mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

The most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drops. The use of antibiotics in an uncomplicated cold is contraindicated and should be scrupulously avoided.

In summary, a cold in pregnancy is more severe and longer lasting. The treatment of the symptoms with local and systemic decongestants will make the patient more comfortable.

Apparently the cold is so common in pregnancy that it has received very little attention in the literature. References are almost non-existent and the few which are available add little to the common knowledge, are out-dated, or are not helpful. Thus the usual bibliography is not appended.



Relieve his sniffles,
her concern, and about
half your phone calls.
Tell her to get
"The Orange Medicine"



Triaminic® syrup

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg
Pheniramine maleate	6.25 mg
Pyrilamine maleate	6.25 mg

For nasal congestion you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)

Pediatrics Society Recommends Attenuated Measles Vaccine

The American Academy of Pediatrics recently recommended that inactivated (killed) measles vaccine no longer be used, and that live, attenuated measles vaccine be given as soon as possible to children who may have received only the killed type of vaccine.

In a statement appearing in the Academy's November 15 *Newsletter,* the AAP Committee on Control of Infectious Diseases also suggests that parents be cautioned about possible local and systemic reactions which may occur when children who have received the killed vaccine are later exposed naturally to measles.

These reactions can include an atypical rash that begins on the feet and spreads upward, high fever, edema, and pneumonia.

The statement also points out that some children who have received the live, attenuated form of vaccine following inoculation with the killed type, have experienced heat, tenderness, swelling of the lymph nodes, and malaise.

A third recommendation calls for children who have underlying illness, or who receive forms of therapy which may render inadvisable the use of live vaccines, to be given immune globulin (human) "for protection on exposure to measles."

The Academy statement emphasizes that the magnitude and incidence of these reactions must still be determined.

But in one town, 11 of 66 children developed abnormal illness when exposed to natural measles "4 years after administration of inactivated vaccine."

In another area, 9 of 31 children had local reactions when given live vaccine "one year after a course of inactivated antigen."

"Reactions of this sort have not been observed with live, attenuated virus vaccine or natural measles unless prior sensitization had been induced by the inactivated vaccine," the statement concludes. Although the development of these reactions has not been fully clarified, "their severity and frequency, and the likelihood that less overt, unrecognized forms may occur, justify a reconsideration of the use of this vaccine at this time."

All-Time Low Is Recorded on Number of Polio Cases

Toward year-end 1967, the U. S. Public Health Service records showed 41 cases of polio, 27 of them paralytic. This is the smallest number of cases reported since the PHS began keeping count in 1913.

Despite this, PHS is warning against complacency. Vaccinations are still necessary and children should still be routinely immunized, the PHS said.

The peak year for polio was 1952, when 57,879 cases were reported.





Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg., chlorpheniramine maleate, 8 mg., and acetaminophen, 500 mg.



Dow PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

in moderate hypertension and
poorly controlled mild hypertension
(when diuretics or sedatives are inadequate, for example)



When your patients expect a lot...

like relief from hypertensive symptoms
(headache, fatigue, nervousness, palpitation or insomnia, for example)

like an up-to-date, once-a-day dosage schedule
(a schedule not unlike timed-release medication, for example)

like a daily dose of medication for peanuts
(at 10¢ a tablet, for example)

like generally well-tolerated therapy
(as described in the package insert, for example)

...give them a little
(one tablet daily)

Regroton®

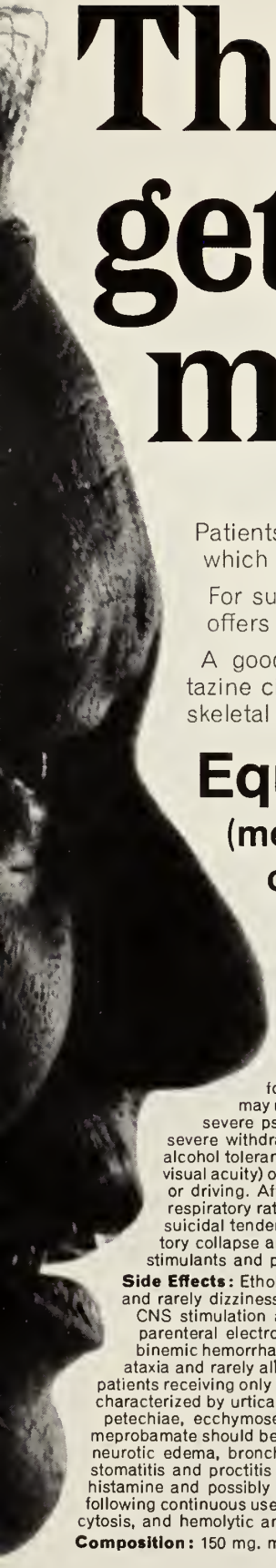
chlorthalidone 50 mg., reserpine 0.25 mg.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
For details, see complete Prescribing Information.

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Geigy





This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

Equagesic® TABLETS

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate Intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Health Insurance Benefits for 1967 at All-Time High

A total of 163 million Americans were protected by some form of private health insurance as the new year began, according to estimates released by the Health Insurance Institute.

It represented a gain of about five million people during the past year and meant that four out of every five persons in the nation are protected by private insurance for health care costs.

The Institute also estimated that Americans received a record $11 billion in private health insurance benefits during 1967 — a gain of over $840 million from the previous year.

Insurance companies, said the Institute, paid out over $6 billion of this figure — an increase of nearly $500 million.

Those persons covered by insurance company policies received $3.1 billion toward hospital bills, nearly $1.8 billion for surgical and medical fees, and $1.2 billion in disability income insurance benefits. The first two categories include $1.5 billion paid out through major medical expense insurance.

The overall insurance company total was about nine per cent higher than the previous year's $5.56 billion benefits.

The coverage figures include an estimated 9 million of the nation's 18.5 million 65 and over population who have health insurance coverage through private sources.

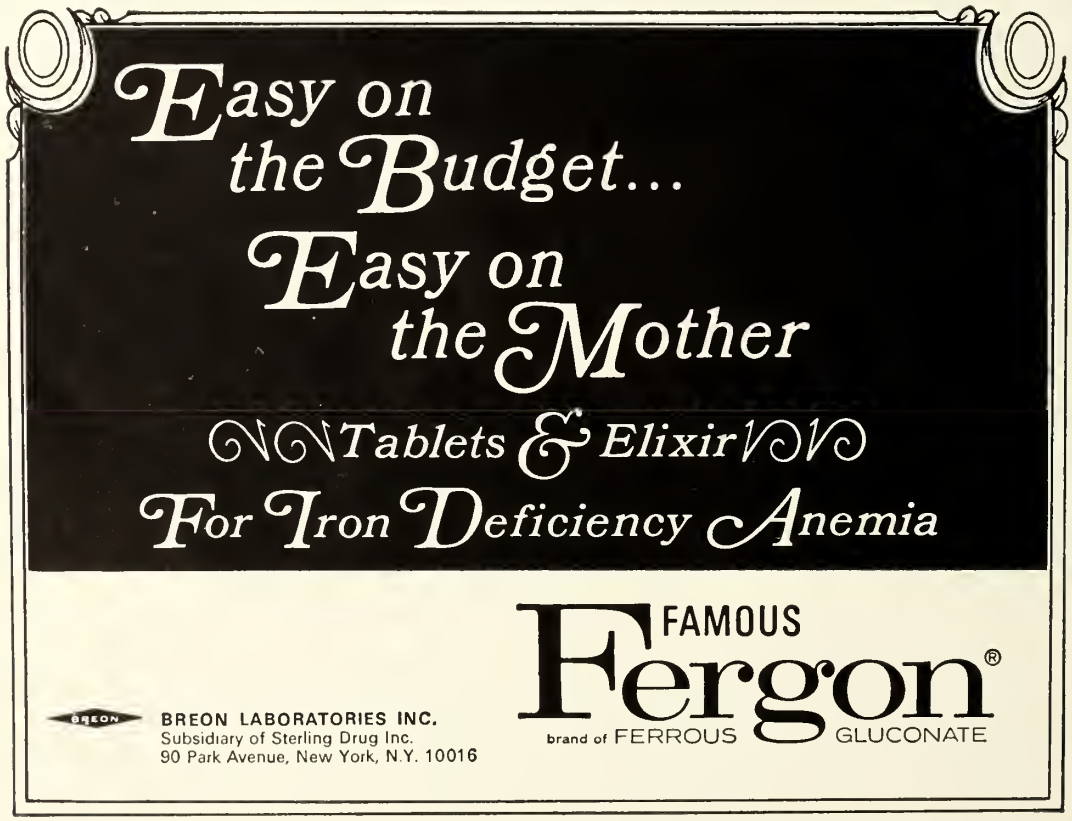
Physicians Invited to Share Journals With Overseas Colleagues

Doctors of the United States are being asked to send their medical journals — after they have read them — to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature, but either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals.

The Doctor-to-Doctor Program of the American Medical Association can supply the individual physician with the names, addresses, and medical specialty of doctors in the areas indicated who would be happy to receive journals, particularly specialty journals. The physician will mail the journals direct to his overseas colleague.

This is a direct "Doctor-to-Doctor" program being sponsored by the AMA with the collaboration of the World Medical Association to help alleviate the lack of current medical publications and to further international good will.

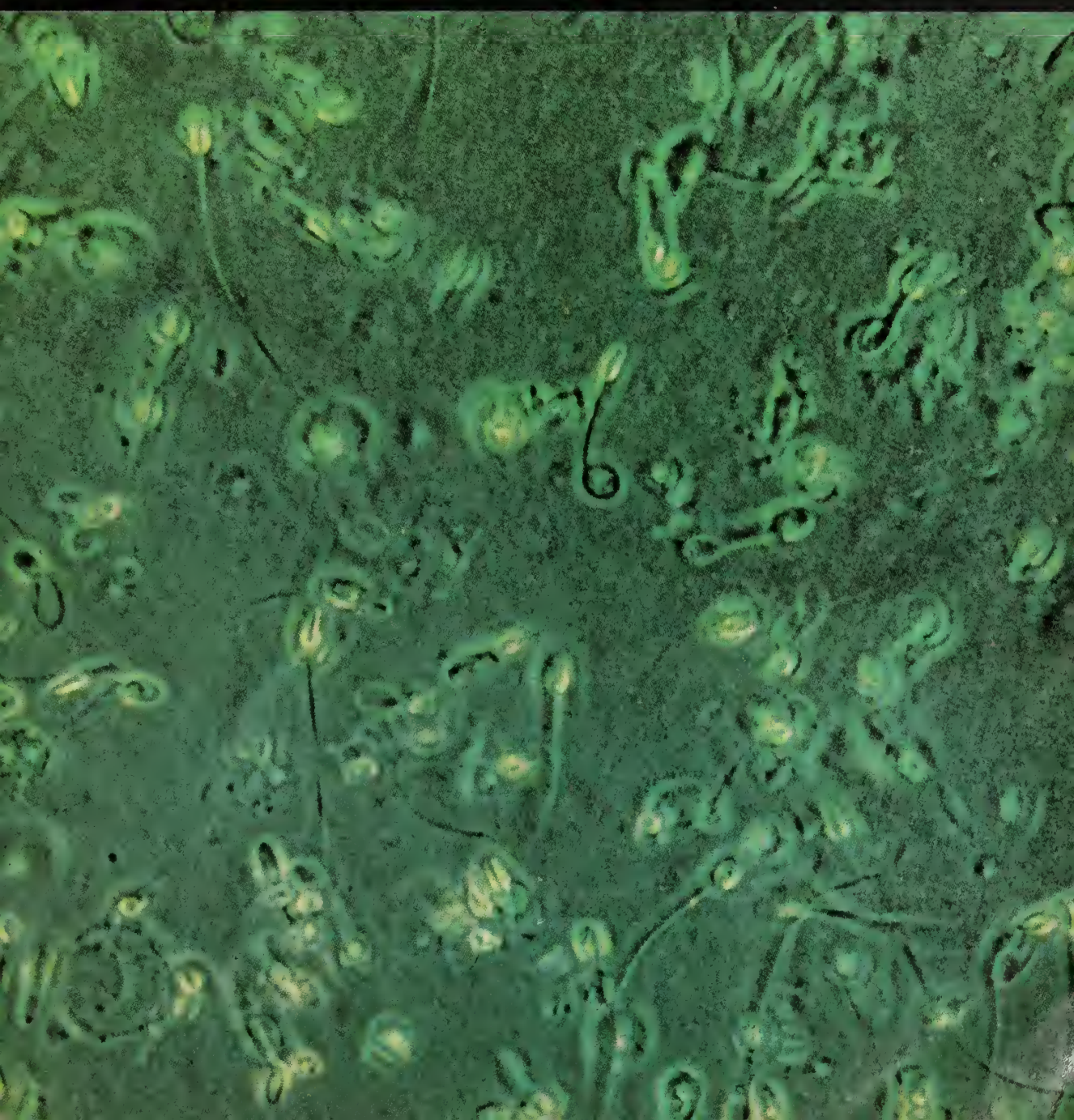
Physicians who wish to participate in the program are invited to send their names and addresses, and titles of journals they are prepared to contribute, to Ada Chree Reid, M. D., Director, Doctor-to-Doctor Program, c/o The World Medical Association, Inc., 10 Columbus Circle, New York, N. Y. 10019.



When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretion, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, change in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmonary embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

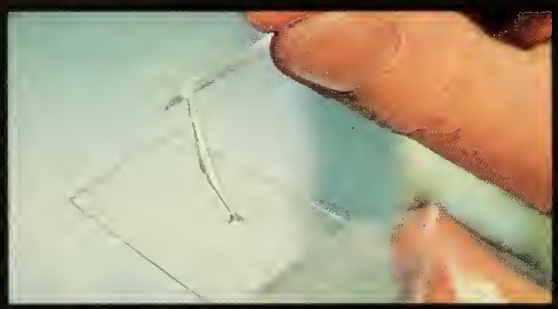
SYNTEX

LABORATORIES INC. PALO ALTO, CALIF

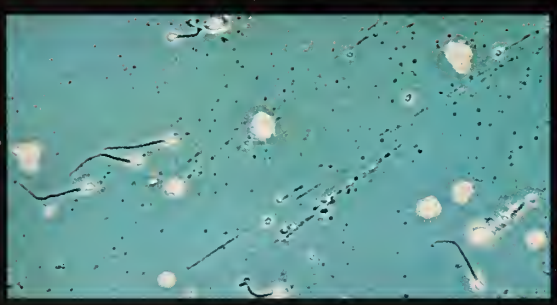
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

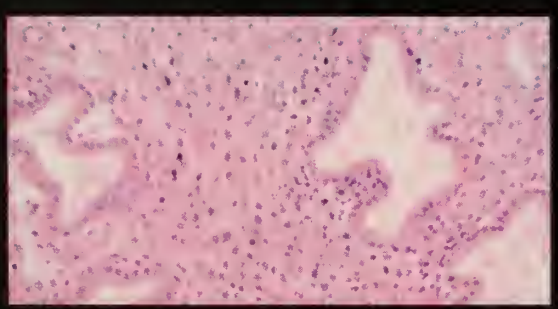
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

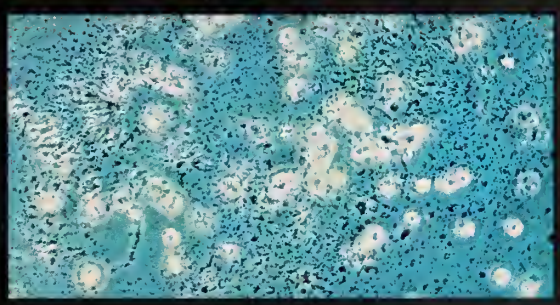


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

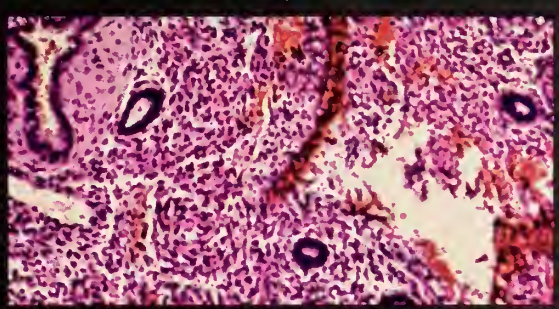
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. & mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide





Turn page for contraindications, precautions and side effects.

For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide — an original steroid from

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LABORATORIES INC., PALO ALTO, CALIF.





"Yes, Doctor, the pain is gone."

EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning – May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.


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Sodium
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800486

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can give him all-day or all-night relief of nasal congestion

SK&F Smith Kline & French Laboratories

Research and Development Funds Shifts Toward Social Sciences. Economics Study Indicates

Total 1968 research and development (R & D) expenditures in the United States are expected to reach $26.5 billion, according to the annual R & D forecast by the Columbus Laboratories of Battelle Memorial Institute.

This is an increase of $700 million, or 3.3 per cent, over estimated 1967 R & D spending.

Significantly, for the first time since reliable figures for total R & D expenditures became available, it is estimated that for calendar 1968 the increase in Federal spending on research in the social sciences will be greater than the increase in the physical sciences.

This change in emphasis is in part due to a sharply reduced rate of growth of military, space, and atomic energy research programs, but is also in large measure due to a national concern with education, health, urban, employment, and welfare problems.

Breaking down the total expenditure estimate for 1968 by source of funds, Battelle forecasts that Federal government spending will total approximately $17.2 billion; industry, about $8.3 billion; colleges and universities, about $865 million; and other nonprofit institutions, $265 million.

This year's forecast, prepared by Battelle economists Ralph L. Craig and Leonard L. Lederman, indicates that the decline in the growth rate of R & D spending in 1967 is likely to continue.

Federal R & D expenditures in 1968 are expected to rise by about $375 million, or 2.2 per cent. Investment in research and development by industry is expected to rise by $380 million, an increase of 4.8 per cent.

In terms of percentage increase, colleges and universities are expected to show the largest gain in 1968. R & D funds from this sector will be increased by $70 million — an 8.8 per cent gain — reflecting in part funds received from foundations and state and local governments.

Viewed in terms of decades, R & D expenditures in the United States for 1965 to 1975 are expected to grow at about the same rate as the Gross National Product (GNP). This would differ from the pattern found in the 1955-65 decade when R & D spending grew at an annual rate of 14 per cent, while there was an annual growth rate of 5.5 per cent for the GNP.

The rate of growth of Federal spending for R & D associated with social problems has been higher than for military/space/atomic energy R & D since 1961, the Battelle economists observe. . . . .

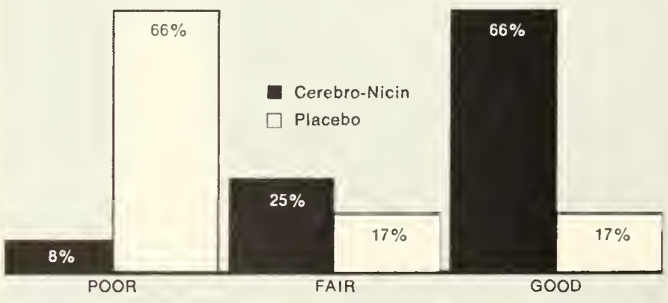
As a result of this shift in the allocation of funds, the Battelle economists say, we are beginning to experience a change in the **kind** of disciplines sup-

For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin® capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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ported by Federal money. The defense, space, and atomic energy programs provide support mainly to the physical and engineering sciences. The major social programs are providing support to many of the behavioral and life sciences.

Since 1965, the Federal share of total R & D expenditures has decreased slightly and, in 1968, it is estimated that Federal funds will account for approximately 63 per cent of the total funds available for R & D. Although industry's share has increased slightly for the past four years, the Battelle researchers do not foresee a return to industry dominance of research funding which prevailed before the 1940's.

Although the Federal government is the dominant source of research funds, industry continues to perform more than 69 per cent of all research. . . . .

Alcohol Implicated in Many Fatal Home Accidents

A study of fatal home accidents among a selected group indicates that alcohol plays an important role in such accidents among young adults and the middle-aged. Home accidents among persons in their prime working years, 15-64, account for about 8,300 fatalities and more than 8.5 million nonfatal injuries annually.

The study covered persons aged 15-64 who died in home accidents during 1964 and 1965. It involved 537 male and 310 female fatalities, of which nearly 15 per cent of the former and about 20 per cent of the latter were found to be associated with drinking.

There were 61 home accident fatalities reported as due to acute poisoning by solids and liquids, and half of these were associated with drinking. Barbiturates were the culprit in nearly 75 per cent of these alcohol-associated poisonings, underscoring the lack of understanding about the accentuated effects of drugs (especially barbiturates) when taken together with alcohol.

Alcohol was involved in nearly 20 per cent of 87 accidental deaths at home reported as due to absorption of poisonous gases and vapors, mostly motor vehicle exhausts.

Falls from stairs or steps accounted for 117 accidents in and about the home, and about 20 per cent of the victims were reported to have been under the influence of alcohol.

Falling asleep with a lit cigaret, cigar, or pipe is a serious hazard for the tired smoker, even when he is not under the influence of alcohol. In the study, alcohol figured in about 25 per cent of the 67 accidental deaths reported as due to fires and other burns among careless smokers.

Drinking was implicated in about 15 per cent of the firearm accidents at home, about 12 per cent of the deaths from choking on food, about 20 per cent of the drownings, and all of the deaths from freezing. — *Metropolitan Life Insurance Company.*



One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) . . . . . (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin . . . . . (2½ grains) 162 mg.
Kaolin (specially purified) . . . . (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER

WILLIAM H. RORER, INC.
Fort Washington, Pa.



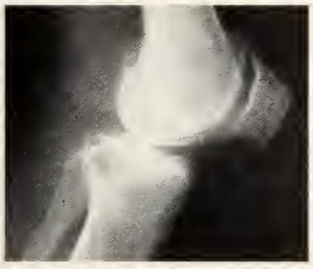
Tandearil®, oxyphenbutazone, 100 mg. tablets

Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis, severe forms of a variety of local inflammatory conditions. (In inflammatory conditions not involving prolonged or fatal disease, use only when severity of condition balances potential toxicity.)
The drug has no significant uricosuric action but is of value only in the treatment of acute gouty arthritis.
Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone, sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, cluding a blood count. The patient should n exceed recommended dosage, should be closely supervised and should be warned tc discontinue the drug and report immediate fever, sore throat, or mouth lesions (symptor of blood dyscrasia), sudden weight gain (wat retention); skin reactions; black or tarry stoc or other evidence of intestinal hemorrhag occur. Make regular blood counts. Discor tinue the drug immediately and institute countermeasures if the white count change significantly, granulocytes decrease, or imr ture forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of t ankles or face may be minimized by with-

"Pain Break" for an osteoarthritic.

Tandearil can ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

holding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. It is usually unnecessary to exceed 4 tablets daily. A trial period of 1 week is adequate to determine response; in the absence of a favorable response, discontinue. Maintenance: An effective level is often achieved with 1 or 2 tablets daily, do not exceed 4 daily. 6562-VI(B)R2

For complete details, please see full prescribing information.

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

TA-6806



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexuol impotence treotment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evongelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 *strengths*

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

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Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white toblet contains:
Methyl Testosterone . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
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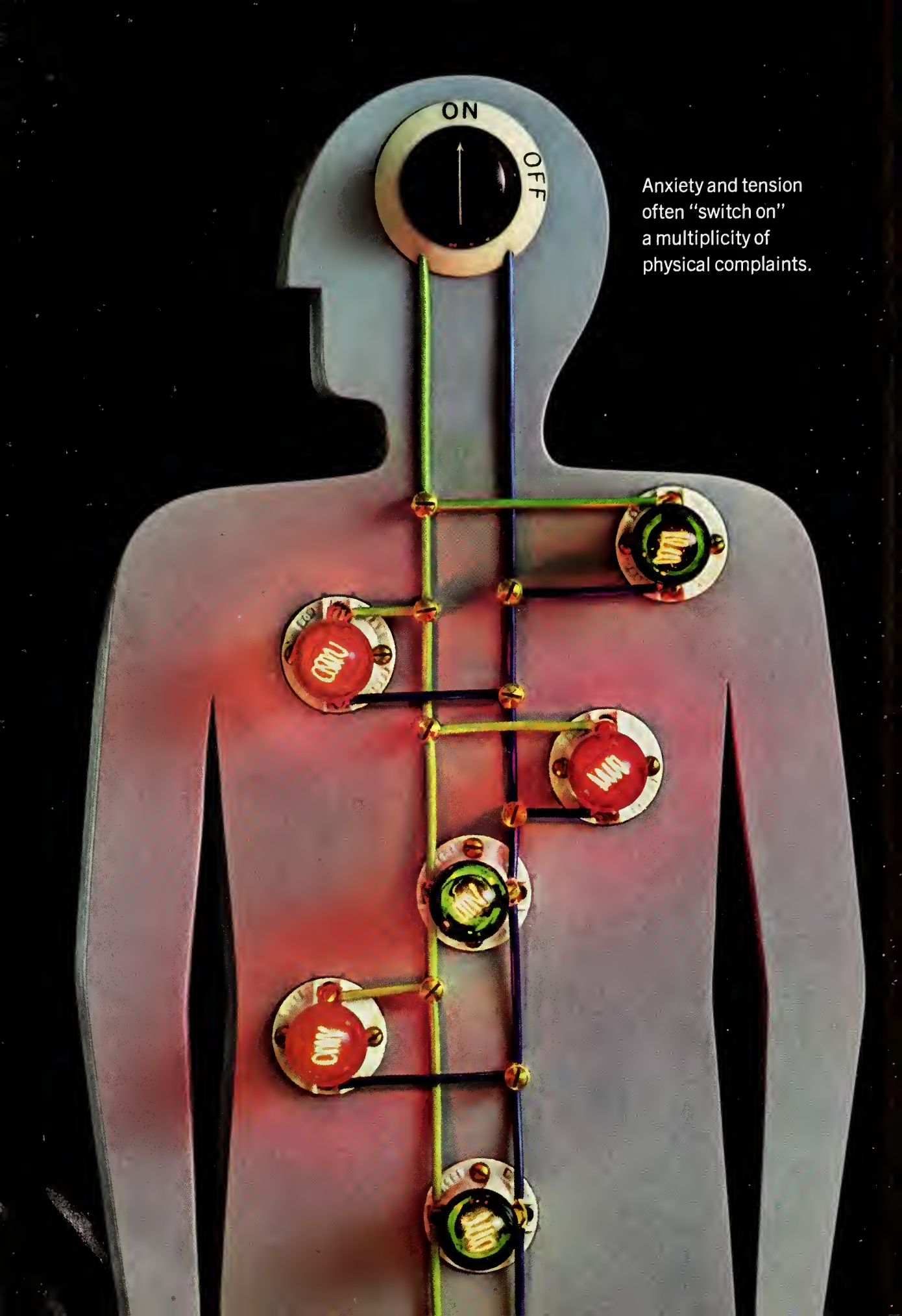
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1. Tybatran often proves more effective than meprobamate and chlordiazepoxide. In one study,[4] severe anxiety responded more effectively to tybamate than to meprobamate; in another,[8] symptom-response superiority of tybamate over chlordiazepoxide was marked at statistically significant levels of confidence.

2. Tybatran appears to be less sedating than other widely used tranquilizers. Side reactions are relatively infrequent; when they do occur, they may take the form of drowsiness, although insomnia, ataxia and other adverse effects have been reported. Nevertheless, Tybatran impresses many clinicians by its comparative lack of undesirable sedative action.[3,6,12,13] (If drowsiness or vertigo is present, activities requiring optimal alertness should be avoided.)

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Dosage and administration. The suggested adult dose of Tybatran (tybamate) is one or two 250 mg. capsules three or four times daily. Dosage should be adjusted to suit individual requirements. While clinical experience with Tybatran (tybamate) in children has been very limited to date, the recommended daily dosage for children 6 to 12 years old is 20 to 35 mg./kg. body weight, in three or four equally divided doses. Dosage should be adjusted to suit individual requirements. Until further clinical experience is obtained, administration of Tybatran (tybamate) to children under 6 years of age is not recommended. Daily doses larger than 3000 mg. are not recommended, although in a few instances doses in excess of this figure have been administered. Tybatran (tybamate) is also available in 350 mg. capsules, for convenience in dosage adjustment, e.g., one capsule three times daily and two at bedtime.

Contraindications. Tybatran (tybamate) should not be administered to patients known to be hypersensitive to the drug. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings. Simultaneous administration to psychotic patients of tybamate with phenothiazines and other central nervous system depressants has in a few instances been associated with the occurrence of grand mal or petit mal seizures. Seizures have been reported with administration of phenothiazines alone, but not with administration of tybamate alone; nevertheless, tybamate should be used cautiously in individuals who are receiving other central nervous system depressants or have a history of convulsive seizures. Also, it should be borne in mind that simultaneous administration of tybamate with alcohol or with other psychotropic agents, particularly phenothiazines or monoamine oxidase inhibitors, which are known to potentiate the action of other drugs, may result in additive actions.

Precautions. There has been no evidence to date of the development of habituation or addiction. Investigators have not observed excessive self-medication or any withdrawal symptoms with use of Tybatran (tybamate), but the latter should be kept in mind with cessation of the drug after prolonged use. Because of the occurrence of

Prescribing information continued on next page.

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Prescribing information continued from preceding page.

withdrawal symptoms or exacerbation of presenting symptoms upon rapid withdrawal of other agents of this type, abrupt withdrawal of Tybatran (tybamate) should be avoided. Tybamate, like other psychotherapeutic agents, should be used with caution in addiction-prone individuals. Should symptoms of hypersensitivity occur, administration should be discontinued at once and appropriate symptomatic treatment initiated. Operation of motor vehicles or machinery or other activities requiring optimal mental alertness should be avoided if drowsiness or vertigo is present. As with any new drug, Tybatran (tybamate), should be used with caution in patients with a history of drug allergies, blood dyscrasias, and hepatic or renal disease; and prolonged and/or high doses of tybamate should be accompanied by periodic measurements of hepatic, hematopoietic, and renal function.

Adverse reactions. While these have only rarely required discontinuation of the drug, the most frequently encountered reactions have included drowsiness, dizziness, nausea, insomnia, euphoria. The drug was discontinued in one child because of a possible drug-induced urticaria, and skin rash and pruritus have been encountered in a few other patients. In a few patients, effects suggesting excessive stimulation such as hyperactivity, fidgetiness, flushing, and tachycardia have been encountered. Other reported side effects recorded only a few times to date have included ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients to whom tybamate (up to 6000 mg. daily), phenothiazines, and other psychotropic agents were administered simultaneously. Convulsive seizures have not been reported with the use of tybamate alone.

Until clinical experience has accumulated with this drug, inasmuch as tybamate is related to meprobamate, the physician should be cautious about the possibility of rare, serious adverse reactions such as may be encountered with the latter drug. Should excessive doses of tybamate be ingested, it is recommended that any drug remaining in the stomach be removed and symptomatic therapy, including central stimulants, be used as necessary.

Supply. Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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Those words are from an address delivered before members of the Rho Chi pharmaceutical honor society at Wayne State University's College of Pharmacy, by Dr. Joseph F. Sadusk, Jr., vice-president for medical affairs at Parke, Davis & Company, leading pharmaceutical manufacturing firm of Detroit.

The former professor of medicine and associate dean for community medicine at Johns Hopkins University School of Medicine, was referring to proposed legislation that would force doctors to prescribe drugs by generic means for patients on Social Security.

He described as "disturbing" the proposed changes which would take away the doctor's prerogative of either himself designating the source of a drug for his patient or leaving this detail to the pharmacist.

Although the proponents of generic prescribing maintain that such drugs are **chemically** equivalent to brand name varieties, Dr. Sadusk pointed out that a number of factors can markedly affect the generic's **clinical** and **pharmacologic** results.

A good case in point, he said, was Parke-Davis' own well-known antibiotic, Chloromycetin.

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2. Only one of the four products tested, Chloromycetin, met all federal labeling requirements.

3. Compared to Chloromycetin, the three generics tested were found deficient in absorbing action from the gastrointestinal tract into the blood stream, and all showed improper excretion rates.

"Herein lies the truth of the matter," Dr. Sadusk said.

"A drug, as a pure chemical, is rarely used in the treatment of patients. Actually, this pure chemical is combined with other agents, usually inert unless the final product is a combination. It is this formulation of the chemical into the final product which the patient receives that may make for substantial

variations in disintegration time, absorption, blood levels, and excretion rates."

The medical director added that although it is generally considered that the agents that are added to the pure chemicals in a drug are usually inert, this is not always so because certain substances may produce undesirable side effects.

Dr. Sadusk emphasized that the Food and Drug Administration (FDA), which regulates the manufacture and sale of U. S. pharmaceuticals, has a duty to arrive at its decisions through "a consensus of informed medical opinion, both within and especially outside the agency."

"But, it is urgently necessary that the FDA not go beyond the point of informing the practicing physician in regulating the type and manner of usage of drugs," the speaker said.

"To tie the hands of a doctor by dogmatic directives in the labeling on the use of a drug, to overemphasize adverse animal data without clinical confirmation, or to stress adverse experiences without a reasonable degree of certainty of a cause-effect relationship, is unjustifiable."

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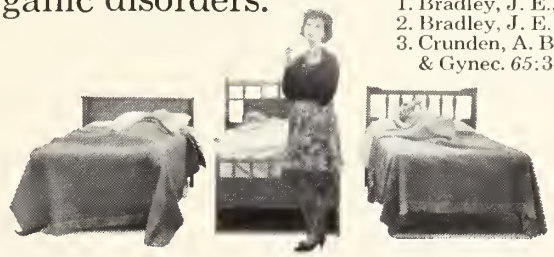
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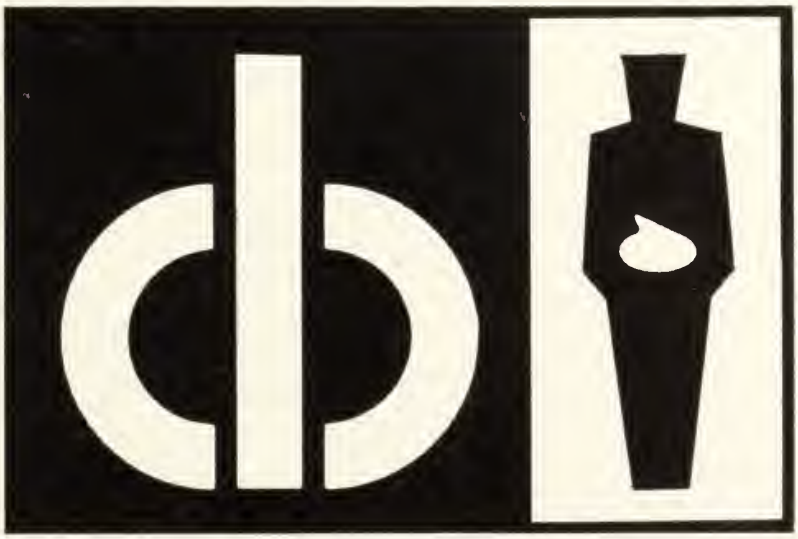
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VOL. 64 FEBRUARY, 1968 NO. 2

Treatment of Status Asthmaticus

A Medical Emergency

JAMES I. TENNENBAUM, M.D., and JOSEPH F. TOMASHEFSKI, M.D.

ASTHMA is a common disorder which is said to affect approximately four and a half million persons in the United States. It is best defined as a chronic disease clinically manifested by wheezing respirations, dyspnea, and cough with production of mucoid sputum, due to bronchiolar obstruction secondary to mucosal edema, bronchial smooth muscle contraction, and hypersecretion. The manifestations are thought to be produced by histamine or other chemical mediators, such as slow reacting substance, bradykinin, and serotonin, which are released by an allergic reaction. Asthma may be seasonal or perennial, extremely mild or severe, episodic or persistent. It may occur alone or in combination with other bronchopulmonary diseases that are accompanied by wheezing, such as bronchitis and emphysema.

Asthma has long been considered a relatively benign disease. Death during an acute attack of asthma was considered to be very rare. Oliver Wendell Holmes, an asthmatic, commented that asthma promotes longevity! "The asthmatic pants into old age" is an aphorism of Osler. In the past 20 years, however, there has been increasing awareness that death from asthma is not unusual. It is estimated that about 5,000 deaths associated with asthma occur each year despite advances in therapy.[1-3] The vast majority of deaths occur in those patients who were in the state of "status asthmaticus". Status asthmaticus is defined as a stage of asthma that is no longer intermittent and that is refractory to bronchodilating drugs, particularly epinehrine, for more than 12 to 24 hours. Status asthmaticus is a true medical emergency requiring immediate hospitalization and prompt intensive therapy, because the patient is in marked respiratory distress and may die.

Submitted August 23, 1967.

The Authors

- Dr. Tennenbaum, Columbus, is Assistant Professor of Medicine, Department of Medicine, Division of Allergy, Ohio State University Hospitals.
- Dr. Tomashefski, Columbus, is Medical Services Director, Battelle Memorial Research Institute; Associate Professor of Preventive Medicine, The Ohio State University College of Medicine.

Treatment of a patient with status asthmaticus must be tailored for each individual case. Several general principles should be followed in order to bring the condition rapidly under control. Table 1 outlines these principles.

Prompt Hydration

A most important aspect of therapy is the maintainance of adequate hydration. Patients with status asthmaticus are dehydrated for several reasons: the severity of the dyspnea; the increased work of breathing; and a decreased oral intake of fluids. Asthmatics lose large amounts of fluid as exhaled water vapor.

The dehydration contributes to the high viscosity of the bronchial secretions. Postmortem examinations of patients dying from asthma show severe hyperinflation of the lungs with thick tenacious mucus filling the bronchial tree. It is apparent that drug therapy cannot be effective until the mucus is thinned and removed from the tracheobronchial tree, either by expectoration or suctioning.

The most efficient method of rehydration and thinning of secretions is by the administration of adequate amounts of intravenous fluids, preferably 5 per cent glucose in 0.2 per cent sodium chloride, supplemented by heated aerosols of normal saline delivered by a small compressor. The use of an intermittent postive pressure breathing (IPPB) apparatus is usually not effective in the immediate treatment of status asthmaticus because the patient has difficulty coordinating his respiratory efforts with the cycling of the machine. In the cooperative patient IPPB can be used to improve ventilation and to deliver aerosols very effectively. In the acidotic, stuporous, weak patient, vigorous use of mechanical ventilation is recommended.

In order to facilitate the liquefaction of secretions, two drugs, N-acetylcysteine and iodides, may be of some value. N-acetylcysteine (Mucomyst®) 0.25-2 cc. given by aerosolization, or more efficiently by direct instillation, decreases the viscosity of the sputum by splitting disulfide bonds in mucus. N-acetylcysteine can irritate the bronchial tree, producing further bronchospasm. If this occurs, its use should be discontinued. Recent evidence supports the view that iodides aid in the liquefaction of sputum;[4] 0.5 to 1 gram of sodium iodide may be added to each intravenous fluid bottle. One should be certain that the patient is not sensitive to iodides before administering the drug. Upon improvement, potassium iodide 10-15 drops can be given orally four times a day.

Correct Metabolic Imbalance

Until recently it was generally felt that epinephrine resistance was due to the respiratory acidosis, which may accompany the inadequate ventilation in status asthmaticus. However, Tsuchiya and Bukantz[5] reported that at least 50 per cent of epinephrine fast patients are not acidotic. In fact, in some cases, respiratory alkalosis due to alveolar hyperventilation is present, especially, with mild bronchial obstruction. They pointed out that all acidotic patients were epinephrine resistant. It is extremely important, therefore, to obtain immediately an arterial blood gas and pH determination to initiate proper therapy. The general availability of new dependable instruments permit simple, rapid, and accurate direct determinations of arterial blood pH, P_{CO_2} and P_{O_2}.

Serial analysis of arterial blood should be performed in the critically ill patient until improvement of ventilation occurs. Arterial puncture is a simple procedure requiring no special skill or equipment. For best results it is imperative that the blood be analyzed immediately after it is drawn. If acidosis is present and the pH is very low (around 7.20), sodium bicarbonate should be added to the intravenous fluids. Hypoxia invariably is also present. Therefore, oxygen should be given by nasal catheter or mask routes, with adequate humidification to avoid its drying effect on respiratory mucous membranes. The P_{O_2} and oxygen saturation are good guides with which to determine the need and concentration of oxygen. Determination of serum sodium, potassium, and chloride levels should also be done to determine the extent to which metabolic acidosis or alkalosis may be playing a role, and therapy should be directed accordingly.

TABLE 1. *General Principles in the Immediate Management of Status Asthmaticus*

1. A medical emergency requiring immediate hospitalization and intensive therapy.
2. Epinephrine by injection is not indicated.
3. Obtain arterial blood gas and electrolyte determinations immediately. Repeat hourly, if necessary, as indicated by the patient's course.
4. Administer fluids and medications intravenously as follows:
   - A. 5% D/W in 0.2% saline, at least 3 liters in 24 hours.
   - B. Aminophylline, 4 mg/kg q. 6 h. for children, 250-500 mg. q. 6 h. for adults.
   - C. Hydrocortisone 100 mg. or its equivalent q. 6 h.
   - D. Correct any metabolic derangements as indicated by blood gas and electrolyte determinations. If pH is low (below 7.20) administer a buffer, sodium bicarbonate, intravenously.
   - E. Sodium iodide, 0.5 to 1 Gm., in each bottle of fluids is valuable is an expectorant.
5. Administer continuous oxygen by nasal catheter or mask with high humidity (heated aerosol) supplemented by aerosol administration of a bronchodilator isoproteronol 1:200½ to 1 cc. q. h.
6. Antibiotic therapy ampicillin or tetracycline in adequate dosage 250-500 mg q.i.d.
7. If the above measures do not quickly improve the severe status asthmaticus, or if acute respiratory failure is present, endotracheal intubation and controlled mechanical ventilation must be employed and carefully monitored.

Bronchodilator Therapy

By definition, the patient with status asthmaticus is unresponsive to epinephrine therapy. Therefore, epinephrine should not be given more than once until hydration and correction of any metabolic disturbance have been instituted. After this is accomplished, 0.1 to 0.3 cc 1:1000 epinephrine may be given subcutaneously every 3 to 4 hours. Initally, aminophylline, preferably by continous intravenous infusion, may be extremely helpful in reducing the severity of the asthma. Aminophylline 250-500 mg. for adults

or 4 mg./kg. for children, should be given over a six-hour period. A word of caution should be added: if aminophylline is given directly intravenously it must be given slowly. Aminophylline should be avoided in the patient who has already received large amounts as it may induce cardiac arrythmias. Aminophylline intoxication has been implicated as a factor contributing to death from asthma, particularly in children.[6] Aerosolization is an effective method of administering bronchodilator topically. One cc. of 1:200 solution of isoproteronol and 2 cc. of saline in a nebulizer may be used in conjunction with the heated aerosol saline solution or delivered independently by a small compressor pump. Hand bulb and Freon® propelled dispensers are ineffective in the management of status asthmaticus. Their value mainly lies in the treatment and amelioration of less complicated asthma.

Antibiotic Therapy

Respiratory infections are a major triggering factor in status asthmaticus as well as a complication. Sputum cultures should be obtained immediately because a bacterial infection may be present and a small broad spectrum antibiotic should be given. Ampicillin, in a patient not allergic to penicillin, and tetracycline are excellent drugs. If the sputum culture sensitivity studies indicate resistant organisms, the appropriate antibiotics can be substituted. Hypersecretion, dehydration, and stagnation of secretions provide an excellent environment for infection. The usual organisms are the pneumococci, hemophilus influenzae, and streptococci, which are readily susceptible to broad spectrum antibiotics and penicillin.

Steroids

The intelligent use of the adrenal corticosteroids may be a life-saving measure. They should be given immediately to any patient who appears critically ill with marked respiratory distress. Steroids reduce mucosal edema and inflammation, thus reducing the associated airway obstruction. Hydrocortisone 100 mg., or its equivalent, should be given intravenously, followed by an additional 100 to 200 mg. in the continuous intravenous drip. As much as 400-600 mg. may be needed in the first 24 hours of treatment. As soon as the patient can take fluids by mouth, 40 mg. of prednisone per 24 hours can be given over the next two or three days. As soon as marked improvement occurs, the dose should be reduced and then discontinued as soon as possible. With intelligent application of the previously mentioned therapeutic measures, prolonged steroid therapy can be avoided in almost every case. ACTH stimulation of the adrenal cortex is usually ineffective as the adrenals are already working maximally in such a stressful situation as status asthmaticus. Since intravenous steroids are rapidly absorbed and dissipated, they should be given slowly by intravenous drip or supplemented in intramuscular or oral routes.

Sedation

These patients are usually fearful, anxious, and agitated, and there is a temptation to use sedation. It should be emphasized that heavy or continuous sedation is contraindicated, because the patient must be alert enough to expectorate bronchial secretions. In general, it is wise to avoid the use of any sedative, but if sedation is necessary, chloral hydrate a mild sedative, is the drug of choice. Morphine and meperidine should *never* be used, as they dry bronchial secretions, produce smooth muscle constriction, and depress respiration. Antihistamines, although mildly sedative, are also *contraindicated* because of their drying action on the bronchial mucosa. Sedatives, antihistamines, and morphine all have been incriminated as important factors leading to death in status asthmaticus.

Mechanical Respiratory Assistance

Occasionally patients with severe status asthmaticus may not respond to the above measures and may progress to acute respiratory failure. Progressive deterioration of the patient's state, with increasing hypoxia and carbon dioxide retention may occur so rapidly that the doctor may be unprepared for a fatal outcome. Ominous signs are a rapid pulse rate, falling blood pressure, a rising arterial P_{CO_2}, or changes in the patient's mental status.

When respiratory efforts become weakened and ineffective or when respiratory failure is present as revealed by blood gas determinations, endotracheal intubation and controlled mechanical ventilation are mandatory. These maneuvers allow for direct access to the lower respiratory tract for good bronchial lavage and better alveolar ventilation. Because of the potential complications of tracheostomy, and the rapidity of patient response, intubation with a cuffed endotracheal tube is the preferred method of facilitating artificial respiration. Mechanical ventilation through the cuffed endotracheal tube may be performed using any of several excellent respirators, either volume or pressure cycled. If the subject is restless and cannot cycle with the respirator, meperidine, morphine or curare-like drugs may be necessary to slow or suppress spontaneous respiration.

When ventilation is taken over by the physician, monitoring by serial arterial blood gas and pH studies is absolutely essential for correct management. Controlled mechanical respiration requires a high degree of technical skill, with close cooperation with an anesthesiologist, inhalation therapist, nurse, and attending physician. It is intensive therapy, requiring constant supervision, since changes take place rapidly and adjustments must be made frequently. The details of the technic of controlled mechanical respiration can be found in several excellent articles.[7-9]

Diagnostic Evaluation

Control of the severe bronchospasm is only the first step in the rehabilitation of the patient. The

physician must renew and intensify all efforts to identify any agents involved in the etiology of the asthma. In particular, he must look for an antigen against which the patient can be hyposensitized, thereby preventing future occurrences of severe asthma. These studies are best done at a later date after the patient has left the hospital and is fully recovered from the episode of status asthmaticus.

Summary

Status asthmaticus should be considered a medical emergency. Intensive, effective therapy must be started early, following certain general principles: Adequate hydration is a key to effective treatment enabling secretions to be more easily expectorated. Bronchodilators should be used intelligently and not given too often or in too large a quantity. Frequent arterial blood gas and pH studies enable proper therapy to be tailored to each patient. A broad spectrum antibiotic should be started early if an infection precipitated or is associated with the attack. Adrenal corticosteroids can be life-saving and should be used in every severely ill patient. Endotracheal intubation and controlled mechanical respiratory assistance are indicated when respiratory failure is present. Rehabilitation and evaluation for factors causing the asthma are best done after the patient leaves the hospital.

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SEPTICEMIA attributable to prolonged venous catheterization occurred in nine patients as a nosocomial infection. In five patients, the sepsis responded satisfactorily to therapy, but in four others oliguria, azotemia and shock developed.

Because of the technical ease with which venous catheters can be inserted percutaneously, they are now used commonly, and are frequently maintained for long periods. The hazards reported here suggest that the venous catheter, however inserted, should be placed only when absolutely necessary, maintained with appropriate aseptic and antibiotic precautions and removed as soon as possible. If the need for catheterization still exists after 48 hours of proper maintenance, a new catheter should be placed at another site. — Helen Smits and Lawrence R. Freedman, M.D., New Haven, Conn.: *The New England Journal of Medicine,* 276:-1229-1233, July 1, 1967.

BOERHAAVE'S SYNDROME. — It has been found in the past two decades that early diagnosis plus an active therapeutic program can lead to a successful outcome in rupture of the esophagus. Treatment consists of conservative management and radical measures: thoracotomy and repair of esophageal rent, surgical drainage of mediastinum, or both. Perforation can occur as a result of instrumentation or foreign body, by a neoplasm or long-standing disease of the esophagus, or spontaneously. — Qamar Ali Khan, M.D., and Elmer N. Zinner, M.D., Johnson City, N.Y.: *New York State Journal of Medicine,* 67:1859-1865, July 1, 1967.

Pellagra

Case Report with Discussion and Historical Review

LEONARD E. HITCHIN, M.D.

THE gigantic strides taken by nutritional science during the past half-century and the existence of our current affluent society are largely responsible for the rapidly diminishing importance of pellagra and similar clinical entities in the United States. In recent decades many previously prevalent disease processes have been so thoroughly annihilated by the advancing medical frontiers that they remain almost as historical curiosities in the wake of this expanding knowledge.

Pellagra, and most other diseases of nutritional deficiency, have today been reduced to such insignificant stature that they are often excluded from a differential diagnosis even when classical patterns for such an entity exist. Because the best interests of the patient are not always served by such exclusions, it is hoped that some benefit may be derived from this review of pellagra . . . a "rare bird" that refuses to become extinct.

A single case report of a recent admission to the Ohio State University Hospital is included herein. It has been incorporated primarily to illustrate the problem in differential diagnosis which such a patient presents and is not intended to represent a typical clinical picture of pellagra. Such a problem will surely become more complex as the chemical and pharmaceutical industries release new products for our Great Society that will produce pellagra-like skin lesions in susceptible individuals.

Case History

This 61-year-old, unmarried, white man was admitted to University Hospital for the first time on April 4, 1967, with the chief complaint of swollen hands and oozing skin lesions. One day prior to admission he had been released from the Franklin County Workhouse, following a two month confinement, from which he was referred to the University Hospital Emergency Room.

Approximately 10 days preceding this admission the patient had experienced onset of a pruritic rash on the back of both hands which was noted to appear on his face, neck, lower legs and feet, and scrotum within 24 to 48 hours. The formation of small blisters on these areas began to occur at this time and these either burst spontaneously or were ruptured by excoriation shortly after they developed. The patient claimed that his skin in these same areas then became intensely red and pruritic and "oozing of sticky fluid" began. This event was soon followed by a crusting of the forearms, hands, face and neck in a symmetrical manner. An exfoliative dermatitis was observed concomitantly on the lower legs and feet.

Previous episodes of a remarkably similar nature reportedly were experienced at intervals of six months to a year since age 29. These apparently were unrelated to the season of the year. A single previous hospitalization in 1945 for a similar dermatological problem was recalled.

A history of heavy ethanol intake since early adulthood was acknowledged. Since the patient was chronically unemployed, he was ostensibly limited to about 10 bottles of beer and a pint of wine per day. His usual diet consisted of black coffee for breakfast, a sandwich for lunch, and a 60 cent meat and potato "Special" for dinner. About half of the latter often remained uneaten because food ingestion was frequently accompanied by nausea. The patient claimed he had smoked about one pack of cigarettes per day for 50 years.

Medications had been limited to Furacin® dressings applied to the lesions within a few days of onset, and hot Epsom salt soaks two to three days prior to admission. Previous allergies were denied.

The review of systems was unremarkable except for a 10 pound weight loss over a several week period. Dysphagia and diarrhea were denied. The past medical history was unremarkable and the family history was noncontributory.

Physical examination upon admission included blood pressure, 118/70 mm Hg; pulse rate, 78 per minute; respiratory rate, 18 per min.; temperature, 99.5 F; height, 60 inches; and weight, 107 lb. The patient appeared to be a short, somewhat poorly nourished white man who seemed slightly older than his stated age. He also appeared moderately fatigued, but was well oriented to time, place and person, and was in no acute distress.

An eczematous reaction with scaling, crusting and fissuring was present almost symmetrically over both hands and forearms. The face and V area of the neck were similarly involved with rather sharp areas of demarcation coinciding with the limits of clothing coverage. An exfoliative dermatitis was also symmetrically located over the anterior surface of the lower legs and feet (Fig. 1). Some degree of hyperpigmentation was also present. Except for a mild erythema and scaling of the scrotum, the remainder of the skin was essentially unaffected.

Hearing was slightly decreased and a perforated tympanic membrane was observed in the right ear. The pupils were equal and reactive to light and accommodation. No nystagmus or extraocular muscle weakness was noted. The optic fundi were normal. Patient was edentulous except for a single mandibular premolar. The tongue was beefy red and glossy in character. The oral mucosa was moist, but the lips

The Author

● **Dr. Hitchin, Columbus, a 1967 graduate of The Ohio State University College of Medicine, presently is an Intern at Mount Carmel Hospital.**

This paper was presented by the author during his senior medical college year, as a requirement paper on a dermatological subject.

were mildly fissured with minimal perlèche. Swallowing was prompt and effortless. No cervical or supraclavicular adenopathy was noted.

There was slight increase in AP chest diameter with a few scattered rales heard at the bases. A Grade II/VI systolic ejection murmur was heard at the apex. The rhythm was regular and no cardiomegally was detected. The abdomen was normal. The extremities revealed no clubbing or cyanosis. The hands were edematous. The dorsalis pedis pulses were weak bilaterally. No peripheral adenopathy was noted. Motor and sensory modalities were normal in the extremities. The deep tendon reflexes were within normal limits, though slightly reduced. Coordination and memory appeared intact.

Laboratory data included a white blood cell count of 9,886 per cu. mm. with normal differential. The hemoglobin was 13.5 Gm/100 ml and the hematocrit was 42 per cent. The blood urea nitrogen was 18 mg/100 ml; blood sugar, 118 mg/100 ml; calcium, 4.5 mEq/liter; sodium, 138 mEq/liter; potassium, 4.9 mEq/liter; chloride, 99 mEq/liter; carbon dioxide, 29 mEq/liter; and uric acid, 4.5 mg/100 ml. The alkaline phosphatase was 1.4 units (KBR) and the icterus index was 4 and 7 on two occasions. The prothrombin time was 81.5 per cent of the control. Total serum protein was 7.6 Gm/100 ml. The serum electrophoretic pattern was normal except for a gamma globulin fraction of 21.1 per cent and an albumin fraction of 48.0 per cent. The electrocardiogram was within normal limits. An augmented histamine gastric analysis revealed an hourly output of 217 ml of gastric fluid containing 22.8 mEq acid. The urinalysis disclosed a specific gravity of 1.016 and a pH of 5.0. An occasional white blood cell was noted. The Venereal Disease Research Laboratory test for syphilis was negative.

Hospital Course

The initial impression on admission was that the patient did indeed have pellagra. Accordingly, he was placed on a niacin deficient diet for the eight day period extending from April 5 through April 12. During this time he averaged 7.1 niacin equivalents per day with an average daily intake of 1,216 calories. A somewhat elevated caloric intake was possible during the first few days by providing the patient with three cans of beer per day. Since beer is somewhat deficient in niacin, a corresponding rise in niacin equivalents did not occur. It was subsequently learned that alcohol ingestion is accompanied by an increase in urinary metabolites of niacin, wherein normal levels are frequently reported for persons who are known to be niacin deficient. Therefore, in order to obtain meaningful assays of these metabolites, the beer ration was terminated on the second day of the special diet.

Except for mineral oil which was provided for symptomatic relief of skin crusting and fissuring, no medication was permitted. During the eight day period in which the patient was on the special diet, he denied onset of any new complaints but claimed that he lacked energy and felt that his dermatitis was becoming worse. This appeared to be the case in fact, for some increase in erythema was observed in the area of the old lesions and, following an episode of accidental increased light exposure, a new area of mild erythema was noted on both upper arms extending to the level of clothing protection. Subsequently, the patient was phototested with a lamp active in the 2800 to 3200°A spectrum and his minimal erythema dose was found to be normal for the lamp.

The area receiving the delayed erythema dose (D.E.D.) showed an eczematous reaction about 48 hours after irradiation, but a similar response was not detected at areas of lower intensity of irradiation. Patch testing demonstrated a positive contact reaction to Furacin, while no response was elicited by DDT, benzocaine, Novocaine®, Surfacaine®, nickle sulfate, basic chromic sulfate, paraphenylenediamine, lanolin, Cordran® with neomycin or paraben. The augmented histamine gastric analysis was within normal limits and small bowel films were not obtained at this time; however, the chest films revealed evidence of emphysema, arteriosclerosis, and degenerative arthritis of the spine.

A 24 hour urine collection was obtained soon after admission to be analyzed for uroporphyrin, porphobilinogen, coproporphyrin, and protoporphyrins. Similarly, aliquots were also assayed for N-methyl-2-pyridone-5-carboxamide, xanthurenic acid and kynurenic acid, three of the end-products of tryptophan metabolism illustrated in Figure 2. A significantly low value of 3.85 mg/24 hours was obtained for the pyridone excretion level. The xanthurenic and kynurenic acid assays were reported to have no detectable amount of either (normal levels are 9 ± 4 mg and 12 ± 5 mg respectively[1]). Three days later, the patient received a tryptophan loading dose (2.0 grams) orally, and a 24 hour urine sample was again collected for analysis of the xanthurenic and kynurenic acid levels. Again none was detected. (Normal values after tryptophan loading are 58 ± 20 mg in both cases.[2]) Unfortunately, a pyridone value was not reported from the second collection. A single blood lactate/pyruvate study was within normal limits.

A 4 mm punch biopsy was taken of a late lesion on the back and left arm. A hematoxylin and eosin stain preparation of each lesion subsequently revealed hyperkeratosis and focal acantholysis with vesicle formation consistent with, but not diagnostic of the histological findings in pellagra.

On the ninth hospital day the patient was started on a regular diet supplemented with 15 mg of oral niacin. An additional 25 mg of nicotinic acid taken by mouth was added to this regimen two days later. A decrease in erythema and some evidence of early healing seemed apparent within 24 to 48 hours. On the second day of therapy the patient reported that he felt more energetic and claimed that the pruritis had decreased significantly. Improvement continued daily and he was discharged on the 15th hospital day to be followed in the outpatient clinic.

Discussion

Even a cursory review of the literature would lead one to suspect that dermatitis is the sine qua non of pellagra. Typically, the lesions in the acute state are described as an erythema resembling sunburn at the onset, developing into rough, scaly areas with vesicles and bullae usually prominent in more severe presentations. The distribution is classically limited to the exposed areas of the skin and occurs symmetrically on the dorsum of the hands, arms, and anterior surfaces of the legs and feet, with relatively sharp lines of demarcation at clothing borders.

Lesions on the face and neck are so common that characteristic involvement of the neck base has become known as Casal's necklace and is almost pathognomonic of pellagra (according to some authors).[3] In addition, areas exposed to irritation or trauma such as the elbows, axilla, scotum, or intertriginous areas may become locally involved.

Subsequent healing often leaves areas of hyperpigmentation. In fact, the chronic form of the disease is generally characterized by hyperkeratinization and pigmentation over pressure points such as the knees and elbows and does not demonstrate erythema or blister formation at all.[4]

Syndrome memorizers usually hasten to add that the above characteristic lesions combined with diarrhea and dementia complete the triad known as the three d's of pellagra. Those who would clutter the literature with more extraneous detail point out that glossitis, stomatitis, gastritis, dysphagia, weakness, weight loss, peripheral neuropathy and a host of more trivial abnormalities such as anemia may be associated with the disease. Clinicians who rely heavily on statistical probabilities may be aided in their diagnosis with the knowledge that diarrhea is reportedly present in one half to three fourths of pellagra cases and

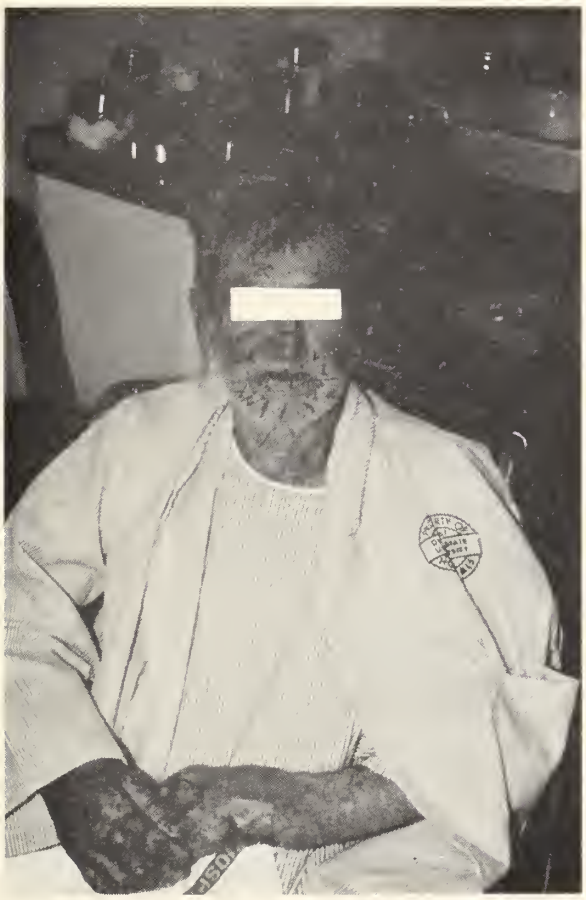






FIG. 1. *A 61-year-old man demonstrating glossitis and a dermatitis typical of pellagra. (April 5, 1967.)*

achlorhydria may be expected in about one half of instances.

The "dementia" has been associated histologically with degeneration of cortical nerve cells with peripheral nuclear displacement and an increase in fat and pigment in the cytoplasm. Peripheral and spinal nerve tracts may show demyelination, especially on the posterior columns of the cord. Clinically, this means that the encephalopathy of pellagra may simulate almost any mental disease. If mental symptoms are present at all, depression, irritability and anxiety customarily predominate, with confusion, hallucinations and delusions often presenting later. The patient may be hyperactive and manic or demonstrate apathy, lethargy and stupor occasionally terminating in coma and death.

It seems apparent, therefore, that pellagra may assume many forms clinically and reliance upon simple criteria such as the "three d's" will surely cause the disease to be ruled out prematurely on many occasions. Indeed, it is perhaps significant that it is recognized even to the extent that it is currently reported. The patient presented herein demonstrated a nearly "classical" dermatitis and glossitis, but failed to exhibit most other well known manifestations of pellagra. Hence, the diagnosis did not seem to be tenable until the causes of similar dermatological conditions could be excluded.

A review of exogenous and endogenous factors producing an exfoliative dermatitis was performed with essentially negative results. An incomplete list of some considerations is included (Table 1). A contact dermatitis was strongly considered but a history of exposure to a likely suspect could not be elicited. Subsequent patch testing, however, demonstrated a positive reaction to Furacin that remained localized and seemed essentially unaffected by exposure to light in minimal quantities. The porphyrias were likewise considered and assays of urinary porphyrins were ordered. The results of the 24 hour quantitative urine porphyrin studies were as follows:

Coproporphyrin	80.4 μg/24 hours.
Uroporphyrin	33.8 μg/24 hours.
d-aminolevulinic acid	2.8 mg/24 hours.
Porphobilinogen	Negative.
Urine creatinine	1.2 Gm.

Total urine volume was 1,310 ml.

Other causes of photosensitivity reactions were similarly reviewed with negative results. The last and least likely candidate to be considered for its ability to simulate pellagra was Hartnup disease. Like pellagra, this is a disease associated with tryptophan and niacin metabolism, but it was promptly excluded because it originates in childhood and is of familial etiology. Thus, at this point, the differential diagnosis had proceeded primarily along the lines of ruling out causes of lesions similar to those observed in our patient. Recapitulation of the magnitude of possible clinical presentations of pellagra (e.g., those listed in Table 2) clearly indicated the need for more specific means to rule-in the diagnosis of this disease.

The elaboration of such a procedure was originally

TABLE 1. *An Incomplete List of Some Factors Producing Exfoliative Dermatitis*

Exfoliative dermatitis has been described by Goodman & Gilman (*The Pharmacological Basis of Therapeutics,* Third Edition) with the following groups of drugs:

Aminosalicylic acid	Organic mercurials
Antithyroid drugs	Paramethadione
Arsenic	Penicillin
Barbiturates	Phenathiazines
Carbarsone	Ristocetin
Chloral hydrate	Streptomycin
Diphenylhydantoin	Sulfonamides
Gold	Tetracyclines
Mephenytoin	Trimethadione

A listing of several common photosensitizers prepared by Stewart, Danto & Maddin (*Synopsis of Dermatology;* C. V. Mosby Co., 1966) include:

Topical Substance	Usual Reaction
Bithionol	Erythema
Tetrachlosalicylanilide	Erythema
Coal tar preparations	Erythema and pigmentation
Perfumes, oil of Bergamot	Pigmentation
Laundry whiteners	Erythema
Parsnip and celery	Vesiculation and bullae
Limes and citrus fruits	Erythema and vesiculation
Ingested Substance	
Phenothiazines	Chloroquine
Tetracyclines	Quinine
Griseofulvin	Psoralens
Sulfonamides	Sulfonylureas
Chlorthiazide	Gold

Exfoliative dermatitis may arise from a pre-existing generalized dermatitis. Frequently a prior history of one of the following is elicited:

Atopic Dermatitis	Seborrheic Dermatitis
Psoriasis	Hypostatic Dermatitis
Allergic Contact Dermatitis	Generalized Eczematous Process

TABLE 2. *Signs and Symptoms Often Associated with Pellagra*

*Dermatitis	*Glossitis
*Face & neck	*Redness
*Hands & arms	*Atrophic papillae
Elbows	*Fissures
*Nasolabial folds	Swelling
*Legs	
*Palms & soles	
Perirectal	
*Scrotum	
Vulva	
Stomatitis	Mental depression, etc.
*Angular fissures	Vaginitis
Cheilosis	Amenorrhea
*Anorexia	Hypomenorrhea
Dysphagia	Herpes of lip
*Weight loss	Conjunctivitis
*Indigestion	Enlarged parotid glands
*Nausea & vomiting	Palpitations
Heartburn	Back pain
Diarrhea (With or without bleeding)	Apathy
Proctitis	Lethargy
Abdominal pain	Apathy
*Weakness	

*Manifested by patient in case study.

Modification of a table illustrating the incidence of signs of niacin deficiency in 16 subjects on an experimental diet. From: Goldsmith, G.: Experimental Niacin Deficiency, *JADA,* 32:312-316 (April) 1956.

dependent upon the finding that pellagra was a result of niacin deficiency. It is well known that niacin (or more appropriately, niacinamide) is an essential constituent of the two coenzymes, diphosphopyridine nucleotide (DPN or NAD) and triphophopyridine nucleotide (TPN or NADP) which are involved in glycolysis, pentose biosynthesis, pyruvate metabolism, and the synthesis of high energy phosphate bonds. According to Goldsmith,[4] over 40 biochemical reactions have been found to be dependent upon those enzymes and she lists their function in lipid, amino acid and protein metabolism in addition to the pathways mentioned above. An extensive review of the biochemistry of niacin and its amino acid precursor, tryptophan, is beyond the scope of this paper, although a review of the essential elements of niacin metabolism is in order (Fig. 2).

Niacin (or nicotinic acid) is available to the body by intestinal absorption of dietary niacin or tryptophan. The conversion of tryptophan to niacin is a relatively inefficient process and it is generally agreed that about 60 mg of tryptophan is required to form 1 milligram of niacin.[5,6] Therefore, calculations of total niacin intake must include not only dietary niacin, but allowances for that amount of nicotinic acid derived from tryptophan conversion as well. The term "niacin equivalents" has been devised to represent this dual source of niacin available to the body and may be expressed as the sum (in milligrams) of ingested niacin plus one-sixtieth of the dietary tryptophan.

For example, a diet containing 10 mg of niacin and 600 mg of tryptophan would also be considered to have 20 niacin equivalents. The Food and Nutrition Board of the National Research Council has calculated the recommended daily dietary allowances by estimating requirements on the basis of body weight and caloric intake, and then increasing the higher figure by 50 per cent. Allowances for adult males are 15 to 19 niacin equivalents daily; for females, 13 to 14 mg; and for infants, 6 niacin equivalents.[4]

Experimental work with niacin deficient diets by Goldberger, Horwitt and Goldsmith are in general agreement that 8 to 9 mg of niacin is required to prevent pellagra. It has already been noted, however, that requirements vary with body weight and caloric intake. In the latter instance, it appears that the minimum amount of niacin required to prevent pellagra is 4.4 mg/1,000 calories, except in diets supplying less than 2,000 calories, in which case 8.8 mg is needed.[5] Diets containing less than 8 mg daily will generally result in clinical pellagra in one to four months.

Previous experience with experimentally induced niacin deficiency has demonstrated the value of monitoring the urinary niacin metabolites N-methylnicotinamide and its 6-pyridone derivative[7-10] (Fig. 2). Normal individuals on adequate diets excrete about 10 to 20 milligrams of niacin metabolites in the urine per day. Of this amount, 5 to 8 mg is N-methyl while the remainder is pyridone. Persons with a relatively severe deficiency usually have a combined excretion of niacin metabolites below 1.5 mg/24 hour period.[4] Therefore, a laboratory method is available wherein a niacin deficiency suggestive of pellagra can be quantitatively detected and, accordingly, a 24 hour urine collection was assayed in this hospital for pyridone derivatives. Although several methods are available for determining niacin metabolites, we were unable to find facilities in this area of Ohio who were prepared to do an analysis for N-methylnicotinamide. This appears to be the most specific means to demonstrate a niacin deficiency and such quantitative information would have been quite helpful in establishing the diagnosis.

Significantly, other disease processes may affect the normal pathway of tryptophan metabolism and cause a secondary niacin deficiency. One of these is an inadequate pyridoxine level which results in a deficiency of pyridoxal phosphate. The latter is a coenzyme necessary in the conversion of 3-hydroxykynurenine to 3-hydroxyanthranilic acid. It is apparent from Figure 2 that such an abnormality will create an accumulation of xanthurenic acid at the expense of the remainder of the niacin pathway. For this reason, a tryptophan loading dose was administered to the patient and levels of xanthurenic and kynurenic acid in the urine were assayed for the next 24 hours. A baseline level had been established in the original 24 hour urine collection. The results of these analytic procedures reported in the case study demonstrated not only a low level of pyridone in the urine, but showed a zero amount of xanthurenic and kynurenic acid as well.

Without repeats and follow-up studies, the significance of these results can only be speculated. Certainly a basis for the development of pellagra can be argued, but an enzymatic block high in the tryptophan pathway may be of overriding importance and must now be considered in planning future studies.

In addition to a dietary inadequacy, pyridoxine deficiency may also be induced by isoniazid therapy—thereby a secondary niacin deficiency. Although most pellagra appearing in the United States today is associated with chronic alcoholism, it is also occasionally seen in patients with cirrhosis of the liver, neoplasia, diabetes mellitus, and malabsorption or chronic diarrheal diseases. Malignant carcinoid tumors may create a niacin deficient state by shunting the bulk of body tryptophan into the serotonin pathway. Finally, niacin deficiency may also be induced by thyrotoxicosis and extended febrile illnesses.

The manner in which the disease is treated seems to depend upon both the severity of the illness and the authority recommending the type of therapy. In general, mild forms of deficiency may be successfully treated with a good "normal" diet and standard oral

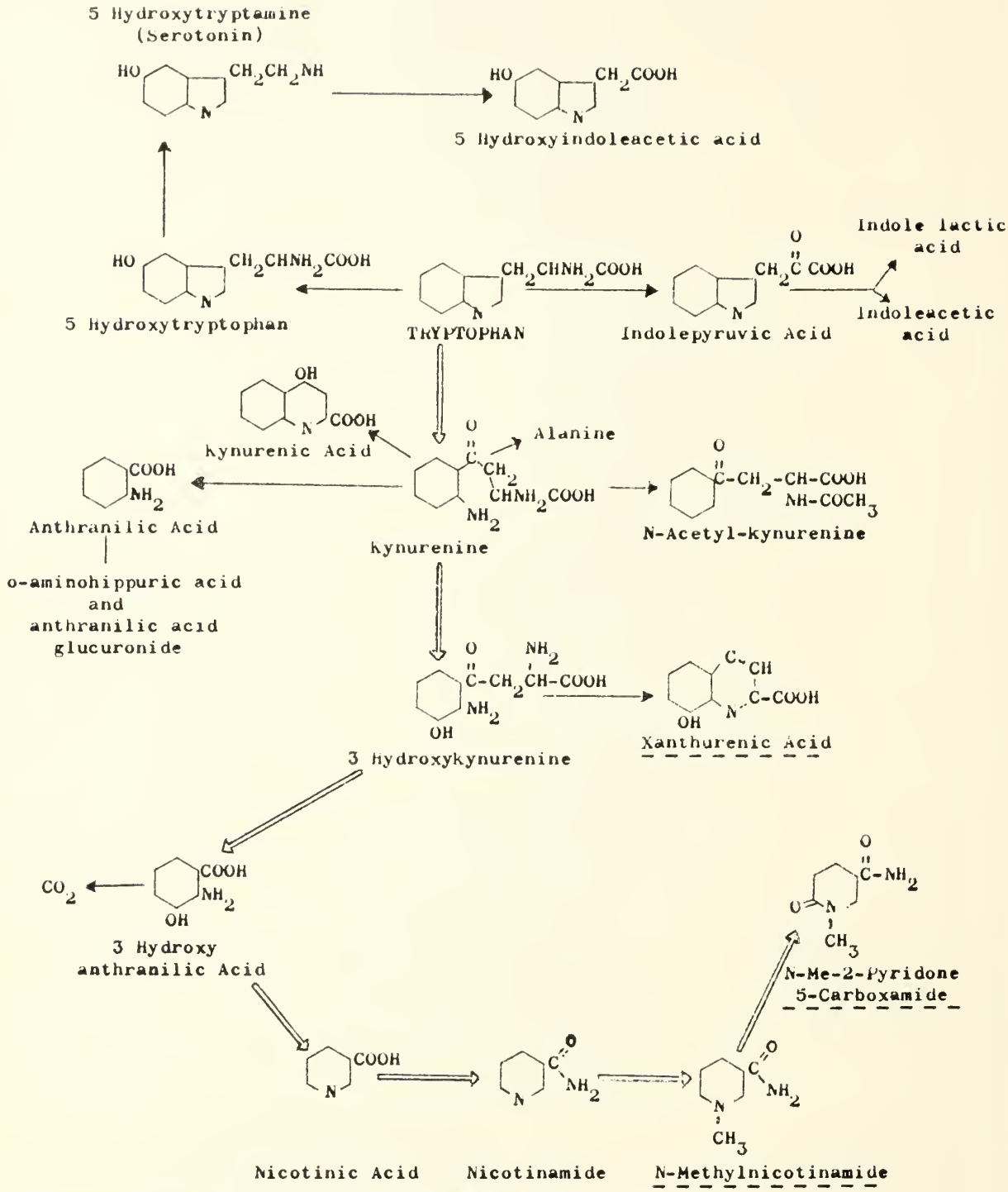


FIG. 2. *Modified Excerpt from Cousin, D.B.: Standardization of the Tryptophan Load Test.* Amer. J. Clin. Nutrition, *14:57, 1964.*

multivitamin therapy. Severe deficiencies may require 300 to 500 mg of niacinamide. This is usually given in divided doses of 50 or 100 milligrams orally or intramuscularly.[1] The mental symptoms and diarrhea usually subside within one or two days after treatment is commenced. Improvements in the dermatitis also occur in one to three days.

Epidemiological History

Perhaps the most fascinating aspect of this disease in retrospect has been the history of its initial reported appearance, rise to prominence, and near demise as a result of the brilliant and methodical work of several investigators. A review of pellagra would be incomplete without reference to these developments and a condensation of significant events is therefore included.

The absence of a description of a disease resembling pellagra in the writings of Hippocrates, Galen and other ancients implies that the disease was essentially unknown until first described by Casal in 1735. It was quite widespread in Spain about 1730 and had acquired the name "mal de rosa" prior to Casal's description. The widespread consumption of Indian corn only shortly preceded the outbreak of pellagra and this relationship was noted by Casal.[11]

In Italy the disease was recognized in 1740 and was subsequently described by Frapolli in 1771.[11] He believed that the common use of maize in the diet and exposure to the sun was responsible for the disease known as pellagra, from the words *pella*, "skin," and *agra*, "unsightly or rough."

The disease was well known in France and Roumania prior to 1820 and was reported in Austria and Hungary in 1887 and 1888, respectively. It was recognized in Russia and Egypt in the 1890's and in the United States Grey in Utica, New York and Tyler in Summerville, Massachusetts each reported a single case in 1864.

Italian investigators were successful in demonstrating early that a good diet prevented the disease, but concluded that the inciting factor must be a contaminant or toxic substance in the maize. Although a few investigators postulated a hereditary or infectious etiology, it remained for the 19th century workers to theorize that a protein deficiency might be associated with the disease. During the opening years of the present century it was found that zein, one of the corn proteins, was deficient in tryptophan and lysine, and Egyptian investigators concluded shortly thereafter that a tryptophan deficiency might be the source of the disease.[12]

The first decade of this century also saw widespread recognition of pellagra throughout the southeastern United States, reaching epidemic proportions among inmates of several of the southern mental institutions. Coincident with the time of this development, "improvements" in milling corn were achieved and a finer, degerminated product was developed with extended keeping properties, so grocers began to stock it exclusively, thereby changing the staple cereal food of a large segment of the population from whole grain to the highly refined product.

In frustration, investigators applied considerable energy toward proving a toxic or infectious etiology which was consistent with contemporary knowledge regarding such epidemic calamities. A special commission was hastily appointed to study pellagra following outbreaks in the Peoria State Hospital and appearance of the disease in Cook County Hospital in 1909. The Commission finding: Pellagra was due to some living micro-organism.

Columbia, South Carolina hosted a National Pellagra Conference in 1912 in which nearly unanimous agreement prevailed among foreign pellagrologists that maize toxin or "mouldy meal" constituted the source of the disease. A single dissenting voice belonged to Sambon who insisted that an unidentified protozoan transmitted by the buffalo gnat caused the disease. This idea found rather wide approval among many American physicians.[13, 14]

Interest in the disease reached national proportions and Joseph Goldberger was assigned by the United States Public Health Service to investigate the etiology of pellagra, commencing his work in 1914.[15, 17] He was able to demonstrate the relationship of faulty diet to the disease and discounted the infectious etiology. Goldberger promoted a diet including milk, eggs, fresh meat, and leguminous protein foods and effected cures in a Mississippi orphanage and in the Georgia State Hospital. In 1915 Goldberger tested his theories by selecting 11 healthy convicts from Mississippi State Penitentiary who subsequently were given a deficient diet similar to that in other institutions where pellagra flourished.[27, 28] After six months, six of the eleven convicts had developed pellagra. Goldberger stated in the conclusion of his report that

> Pellagra may be prevented completely by a suitable diet without intervention of any other factor, hygienic or sanitary. There is no sound evidence that the disease is controllable in any other way.

He added,

> In relation to the production of pellagra, this study suggests that the dietary factors to be considered as possibly essential are (1) an amino acid deficiency; (2) a deficient or faulty constitution of the mineral supply; possibly, but doubtfully, (3) a deficiency in the fat soluble vitamin intake; and perhaps (4) an as yet unknown (vitamine?) factor.

Although Goldberger was aware of the suggestion by Funk in 1912[12] that pellagra might be due to a "vitamine" deficiency in maize, and knew that Osborne and Mendel had shown in 1914 that cystine and tryptophan were essential for growth but were deficient in zein, he seemed preoccupied with the

task of proving the dietary origin. While Goldberger was conducting his investigations, the Thompson-McFadden Commission was concomitantly evaluating the infectious aspects of the disease.[18] Although they were unable to reproduce the disease in monkeys and baboons by injecting blood, urine, cerebrospinal fluid, and tissue filtrates from patients with pellagra, nor by feeding feces and tissue squames from the same patients, skeptics felt that these negative results did not rule out an infectious etiology in man.

Consequently Goldberger and 15 associates administered the coup de grace to the infectionists with an unparalleled display of heroism at Spartanburg when they injected themselves with blood, ingested excreta and squames, and swabbed nasopharyngeal secretions on their throats from patients who were severely ill with pellagra.[19] Some of the volunteers apparently had misgivings about swallowing the dosage because the feces, urine and squames were later placed in capsules to assure more "palatability." None of the volunteers was ill after six months.

In 1922, Goldberger and Wheeler were able to produce blacktongue in dogs by employing essentially the same diet as that used previously in the study with convicts.[20] It was observed that meat, milk or yeast produced a cure and subsequent investigation of yeast revealed that it contained a substance that could be removed by adsorption that Goldberger called "pellagra preventive factor." This knowledge prompted him to revert to the vitamin deficiency hypothesis. Goldberger and Rogers[21] successfully employed oral liver extract to prevent blacktongue in 1924 and, following Goldberger's death in 1929, Sebrell[22] produced rapid cures of blacktongue with the same preparation.

The year 1929 was also significant in other respects as well, for the incidence of pellagra reached its peak at this time. According to Sydenstricker,[14] "reported deaths exceeded 7,000 in 1928, 1929, and 1930 and there were probably more than 200,000 pellagrins in this country."

Pellagra ceased to be a clinical enigma in 1937 when Elvehjem and his associates at the University of Wisconsin isolated niacinamide from the liver and subsequently administered niacin or its amide to dogs with blacktongue and effected rapid cures.[23 24]

Although nicotinic acid therapy appeared to be specific for pellagra, problems soon developed in patients who were maintained on their pellagra producing diet with nicotinic acid supplement. It was observed that many patients experienced cure of their glossitis, dermatitis, diarrhea, and dementia while developing or retaining seborrheic dermatitis of the face, dyssebacea over the malar eminences, nose or chin, fissures of the commissures of the eyelids and lips and a purplish-red colored tongue with flattened papillae. In addition, scaling of the lips with burning and hyperesthesia of the lips, tongue, and pharynx often prevailed. Sebrell and Butler reported in 1938 that similar lesions had been experimentally produced with riboflavin deficient diets and the probability of a multiple deficiency state in many cases was recognized.[25]

After Rosen and his colleagues demonstrated the presence of the metabolite N-methylnicotinamide in the urine of tryptophan fed rats, it remained only for the elaboration of the tryptophan-niacin pathway to complete the picture of pellagra as a disease entity.[26]

Summary

A 61-year-old man demonstrating glossitis and a dermatitis typical of pellagra is presented. The diversity of clinical manifestations of this disease are discussed and an attempt is made to review some of the essential elements to be considered in the differential diagnosis. Laboratory values obtained on this patient suggest a niacin deficiency and an abnormality of the tryptophan-niacin metabolic pathway. A summary of the epidemiological history of pellagra is included.

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Primary Ovarian Carcinoma

FAYIZ A. SALWAN, M.D.,* ABDUL F. NAJI, M.D., and W. F. BOUKALIK, M.D.

OVARIAN cancer continues to be a growing problem. It is the second most common malignant disease of the female genital organs, being exceeded in frequency only by cervical carcinoma.[2] It does not present early warning and most of the cases are discovered when the disease is widely disseminated. The overall therapeutic results today are no better than in the past decades. Recent statistical studies indicate that cancer of the ovary causes the death of 8,900 women every year in the United States.[2] In California it causes as many deaths as cancer of the cervix[7] and in New York State it causes more deaths than cancer of the cervix.[22]

The improvement in diagnostic technic, early detection, and advances in therapy that increased the survival rate of cervical cancer have not been applicable to cancer of the ovary. The ovary is relatively inaccessible to direct and repeated periodic examinations as is the cervix. It can be palpated, often inaccurately, but cannot be visualized easily, and more important, tissue cannot be removed for biopsy. It is the site of many varieties of neoplasms. Exfoliative cytologic study of the ovary is a complicated procedure as compared to that of the cervix.[13, 14] It cannot be repeated as often and seems to offer little hope in early detection of this disease.

The gravity of ovarian cancer and its increasing incidence due to increase in life expectancy, merit further and continued evaluation of this problem.

Material and Method

Eighty-five cases of primary carcinoma of the ovary were seen at St. Alexis Hospital during the years 1953 through 1965 (Table I). The diagnosis was confirmed by pathologic examination in all cases. The available clinical data and pathologic material of each case were reviewed. Follow-up has been possible in all but two patients. During the same period 125 cases of benign tumors of the ovary were also encountered (Table II).

In order to evaluate the results of therapy we have followed the staging classification proposed by Munnell and Taylor,[18, 21] based on the findings at the initial surgical exploration:

Stage I.	Cancer limited to one ovary.
Stage II.	Cancer limited to both ovaries.
Stage III.	Cancer involving the pelvic viscera or pelvic peritoneum.
Stage IV.	Cancer extending beyond the confines of the pelvis.

An attempt has also been made to indicate the prognosis in relation to the type of tumor, though grading of the malignancy was not used.

Clinical Findings

The youngest patient is 24 years old and the oldest is 78; the majority fall between 41 and 69 years, (Graph I).

Abdominal pain and swelling were the most common symptoms, noted in 57.7 per cent and 49.4 of the cases respectively (Table III). The pain was mild, crampy, and usually localized to the lower abdomen. Torsion of the tumor pedicle with rupture of, or hemorrhage within the tumor, caused acute severe abdominal pain. This was present in six patients, three of whom had granulosa cell tumors (Fig. 1). Abdominal enlargement was due to sizeable tumor and/or ascites.

Postmenopausal vaginal bleeding was more frequent than has been reported in other series.[8, 9] It occurred in 15 patients (17.6 per cent), seven of whom were five or more years post menopausal and had no apparent pathophysiological reason for the vaginal bleeding. A probable explanation is an associated endocrine manifestation, hyperestrinism, which

*This work was carried out during the tenure of a Clinical Fellowship from The American Cancer Society, Cuyahoga County Unit.

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The Authors

- Dr. Salwan, Cleveland, is Associate Director of Education in Surgery, St. Alexis Hospital, Cleveland.
- Dr. Naji, Cleveland, is Director, Department of Pathology, St. Alexis Hospital.
- Dr. Boukalik, Cleveland, is Medical Director, St. Alexis Hospital.

had been attributed to a variety of ovarian tumors previously considered endocrinologically inert.[1, 11, 17]

Hirsutism was present in one patient with papillary serous cystadenocarcinoma. This may be due to an endocrine manifestation of the tumor.[5, 24]

The duration of symptoms ranged from one week to four years, in the majority from three to five months.

A palpable pelvic mass was present in all but one patient. Intravenous excretory pyelogram and barium enema examination demonstrated pelvic masses that were missed on initial physical examination in two patients.

Pathological Findings

Papillary serous cystadenocarcinoma was the most common malignant ovarian tumor, 53.3 per cent (Table I). Serous cyst was the most common benign tumor, 46.4 per cent (Table II). Two patients with papillary serous cystadenocarcinoma had unilateral oophorectomy six and sixteen years earlier (at ages 40 and 44 years) for papillary serous cystadenoma. Two patients were originally diagnosed as having serous and mucinous cystadenomas, but on follow-up

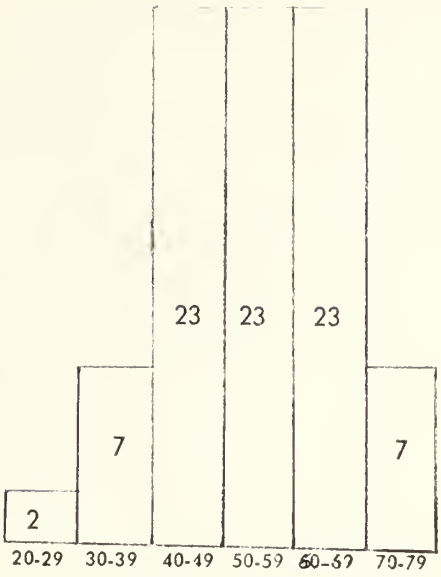
TABLE I. *Primary carcinoma of the ovary (85 patients)*

Stage	No.	Dead	Alive
Serous Cystadenocarcinoma (47)			
I	11	2+1[p]	8
II	3	1	2
III	12	4	8
IV	21	18	3
Mucinous Cystadenocarcinoma (7)			
I	5	2[i]	3
II	1	0	1
III	1	1	0
IV	0	0	0
Anaplastic Adenocarcinoma (15)			
I	2	1[p]	1
II	0	0	0
III	1	1[p]	0
IV	12	12	0
Medullary, Solid Adenocarcinoma (7)			
I	0	0	0
II	1	1	0
III	2	2	0
IV	4	4	0
Adenoacanthoma (1)			
III	1	0	1
Dysgerminoma (1)			
III	1	1[p]	0
Embryonal Carcinoma (1)			
IV	1	1	0
Granulosa Cell Tumors (6)			
I	5	0	5
IV	1	1	0

i = died of intercurrent disease one year and 13 years after treatment; free of ovarian cancer.
p = post-operative death.

TABLE II. *125 Cases of Benign Tumors of the Ovary:*

Serous cyst	58
Mucinous cyst	29
Dermoids	23
Fibromas	9
Thecoma	5
Brenner	1
	125



GRAPH I. *Age incidence. Number of cases by decades.*

the tumors had recurred and were proven to be malignant.

Since the majority of the ovarian tumors are cystic, the surgeon is often confronted at the time of surgical exploration with the question of benignancy or malignancy. A knowledge of the gross appearance of all ovarian tumors is of great help. A thick wall, adhesion of the cyst to other structures, presence of hemorrhagic fluid inside the cyst without torsion of

TABLE III. *Incidence of the Main Symptoms*

Symptoms	No. of Cases	Per Cent
Abdominal pain	49	57.7
Abdominal enlargement or swelling	42	49.4
Post menopausal vaginal bleeding	15	17.6
Urinary tract symptoms	10	11.7
Menometrorrhagia	8	9.4
G. I. Symptoms	8	9.4
Loss of weight	6	7.1
Weakness	4	4.7
Heaviness or pressure in the pelvis	4	4.7
Intestinal obstruction	3	3.5
Migrating thrombophlebitis in legs	2	2.3
Hirsutism	1	1.1
Unsuspected finding	1	1.1

the pedicle, and friable papillary growths on the inner or outer surfaces strongly suggest malignancy. These were frequent findings in the present series. Failure to recognize them resulted in incomplete surgical treatment.

Six cases of the 85 satisfied all the criteria for multiple metachronous primary neoplasms,[3, 12, 20] five with double primaries and one with three primaries, an incidence of 7.1 per cent. One patient had synchronous double primaries: a bilateral pleomorphic papillary cystadenocarcinoma with foci of granulosa cell type and an early well differentiated adenocarcinoma of the endometrium (Figs. 2, 3 and 4). Three

of the seven patients had type A blood, three type O, and in one the blood type was not recorded.[11]

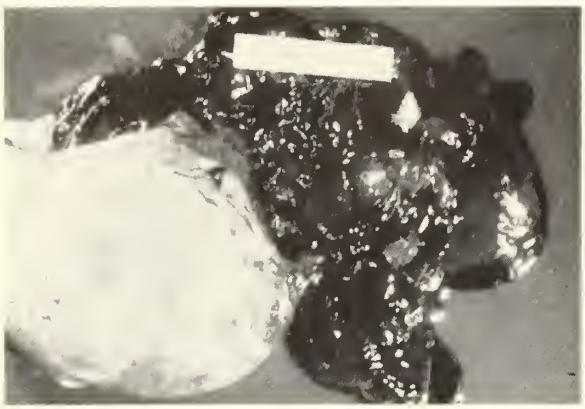


Fig. 1. *Gross Specimen. Granulosa cell tumor showing massive hemorrhage.*

Treatment

Various surgical procedures were employed: Only biopsy was done in the majority of patients with advanced disease, removal of as much as possible of the tumor, unilateral salpingo-oophorectomy, and hysterectomy with bilateral salpingo-oophorectomy.

During the early part of the period under study, unilateral salpingo-oophorectomy was performed in

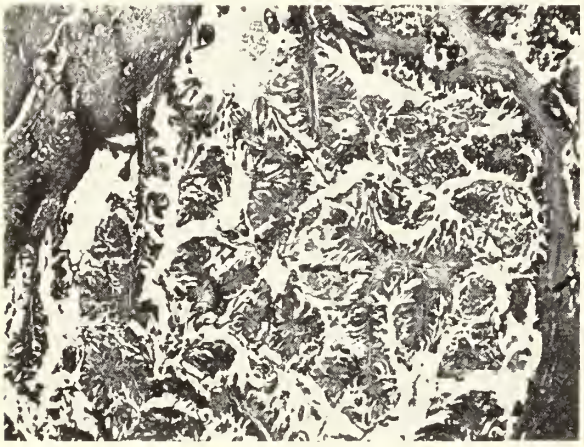
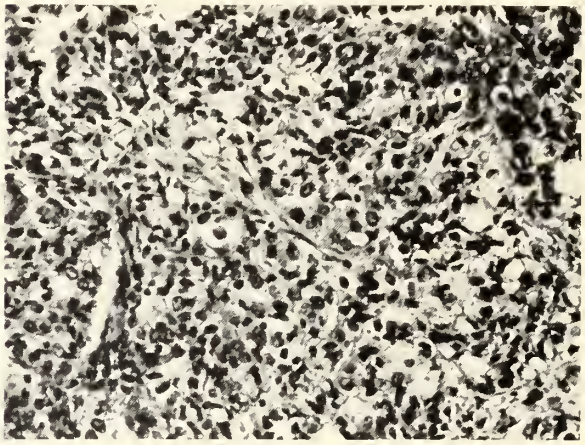


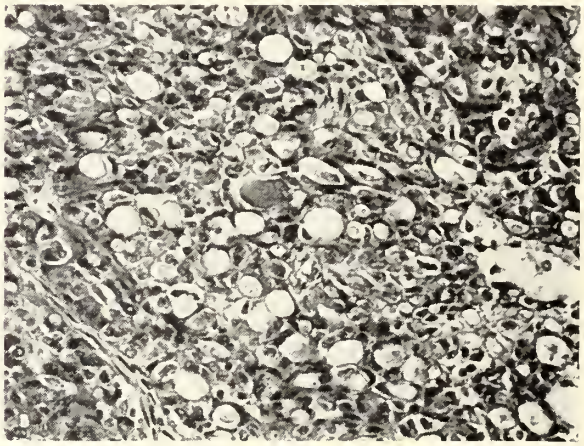
Fig. 2. *Photomicrograph. Papillary cystadenoma of ovary. X33.*

the majority of patients with Stage I disease, even in patients over 40 years of age. The uninvolved ovary was not bisected for complete examination. One of these patients was reoperated upon a week later for wound dehiscence. The normal appearing ovary was removed and proved to contain similar mucinous cystadenocarcinoma. Another patient who had papillary serous cystadenocarcinoma was reoperated on for a similar lesion of the other ovary three years later. Both are still living and free of disease nine and twelve years after the second procedure. Two other patients died of papillary serous cystadenocarcinoma of the ovary one and two years after the initial conservative procedure. Rupture of the tumor with spillage occurred in these two instances.

Four of the 85 patients died in the postoperative period, giving an operative mortality of 4.7 per cent. One patient died as a result of the disease and three as a result of unrelated causes.

Previous abdominopelvic operations had been performed on six patients (7.1 per cent). Two patients





Figs. 3 & 4. *Photomicrographs. Same case as in Fig. 2. Tumor showing solid carcinoma simulating granulosa cell tumor. X325.*

were under 40 years of age at the time of the initial operation and four were over 40 years. The interval between the previous surgery and the discovery of the ovarian carcinoma was six years or more.

Twelve patients with Stage I disease received radiation therapy in addition to surgical treatment. The indication was rupture of the tumor with spillage at the time of the surgery. Dosages of radiation ranged from 4000 (2x2000 large anterior and posterior parts) to 12,000 roentgens (6x2000, pelvic cycle). Two of the 12 patients died of the disease, one and two and one-half years later, respectively; both had only unilateral salpingo-oophorectomy and received only 4000 roentgens. Spontaneous incomplete fracture

of the right femoral neck occurred in one patient six years after complete pelvic cycle.[25]

Three patients had Stage II disease and received postoperative radiation therapy, complete pelvic cycle, 12,000 roentgens. The surgical treatment was complete in one patient who is free of symptoms nine years later. It was incomplete in two patients who died of the disease four months and three and one-half years later.

Eleven patients with Stage III disease received radiation therapy in addition to surgery. One died during the postoperative period as a result of uncontrollable diarrhea. The surgical procedure consisted only of biopsy in two patients; both had very little palliation. Excision of all gross tumor was done in eight patients. All are still living two to eleven years later.

Postoperative radiation therapy either alone or in combination with chemotherapy was utilized in 20 patients with Stage IV disease. The longest survival was three and one-half years. The combination seemed to be more effective than either alone, particularly when surgery consisted of removal of the major part of the tumor masses.

Discussion

The survival rates differ in different histologic types. Anaplastic carcinoma, solid adenocarcinoma, dysgerminoma, and embryonal carcinoma tend to be of high grade malignancy with poor prognosis. Preoperative x-ray examination of the colon and intravenous excretory pyelogram may provide information of prognostic significance. Fourteen patients in the present series had constant narrowing of the rectosigmoid colon with preservation of the normal mucosal pattern. These were found to have advanced disease at the time of surgical exploration with involvement of the rectosigmoid colon. All died within nine months. Six of the above 14 patients had either unilateral nonvisualization of the kidney or hydroureter.

Thirty-two patients of the present series are alive and 53 are dead (Table I). Absolute five year survival figures are available in only 47 cases; 13 (27.6 per cent) survived five or more years. This compares favorably with figures reported in the literature, [1, 19, 21, 23, 26] although some series show considerably higher survival rates.[16, 27] The combined five year survival rate for Stages I and II is 71.4 per cent, Stage III, 33.3 per cent, and none of the patients with Stage IV disease survived five years (Table IV).

Our study as well as others indicates that the extent of the disease is the determining factor in survival. There has been no significant increase in the early detection of ovarian carcinoma recently. More than two-thirds of the patients had advanced disease at the time of the initial therapy. There was a delay in instituting therapy in 9 of the 85 cases. Patient-responsible delay was evident in five cases and the duration was nine months to three years. All five patients died a few months after the initial treatment. Many patients had had no medical or pelvic examinations for many years before the diagnosis was established. Physician-responsible failure to institute prompt therapy was evident in four cases. The duration of delay was nine months to four years. The surgical therapy was inadequate in a few other cases.

All this indicates that public and professional education concerning the manifestations of this disease, its epidemiology, and its therapy could be a possible means of earlier detection and could result in more cures.

TABLE IV. *Survival rates correlated with clinical stages (1953 to 1960), 47 cases*

Stage	No. of Cases	Alive 5 Yrs. No.	Percent	
I	12	8	66.6%	71.4%
II	2	2	100 %	
III	9	3	33.3%	9.1%
IV	24	0	0%	
Total	47	13	27.6%	

Summary

Eighty-five cases of primary carcinoma of the ovary are reported. The peak age incidence was in the age group 40 to 69 years. The most common symptoms were abdominal pain and swelling. Serous tumors were the most common and appeared to be more malignant than the mucinous. Solid tumors, with the exception of the granulosa cell variety, were most lethal. The finding of constant narrowing of the colon on barium enema examination was an indication of the gravity of the disease. Nonvisualization of the kidney on intravenous excretory pyelogram was further evidence of poor prognosis. Absolute five-year survival rate was available in 47 cases (27.6 per cent).

We believe that the most effective approach to this disease is early diagnosis and complete surgical therapy: Total hysterectomy and bilateral salpingo-oophorectomy. Conservation of the ovary may be permitted in a childless young woman, but this carries with it a great responsibility. That ovary should be bisected and examined carefully. Radiation therapy is more likely to be effective when all gross tumor has been extirpated.

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CERVICAL DISC INJURY. — Primary traumatic cervical disc disease and chronic disc disease associated with spondylitis aggravated by injury causes referred pain to the head, face, neck, arms, shoulders and chest, and even in the low back. Such pain may be reproduced by the injection of contrast medium for cervical discography. Dorsal nerve root pain is rare.

Clear-cut disc derangement or annular incompetence may be demonstrated by discography at levels which reproduce symptoms. The pain pattern at each level is not consistent.

Conservative treatment, involving primarily the use of a cervical extension collar, results in substantial improvement in 75 per cent of cases. — F. W. Gorham, M. D., Santa Ana, Calif.: *California Medicine,* 101:363-367, November, 1964.

THE BRAIN-INJURED CHILD. — Convey to your patients that there are only two ways of responding to a handicap: (1) Spend the rest of your life unhappy and feeling sorry for yourself. (2) Learn to make the best of your assets and become independent and self-sufficient as early as possible. Expectations grounded on pity and pessimism tend to feed the child's symptoms, whereas expectations based on confidence tend to help him achieve a confident and comfortable identity. — Sol Gordon, Ph. D., New York: *Clinical Pediatrics,* 5:647-649, November 1966.

The Rh Sensitized Patient

A Discussion of Current Management

DANIEL G. WITMER, M.D., WILLIAM C. RIGSBY, M.D., ALEX F. ROBERTSON, M.D., AND C. MICHAEL THORNE, M.D.

MANAGEMENT of the Rh sensitized patient in recent years has changed dramatically. In 1951, Diamond, Allen, and Thomas described a method of exchange transfusion that became widely accepted and gave new hope to the erythroblastotic infant that was born alive.[1] Management then focused on detection of maternal antibodies, and attempts were made to assign significance to a rise or fall of the titers. These serial determinations were correlated with the obstetrical history of the patient, and a decision regarding pre-term induction was made, often with disheartening results. The difficulties in this system arose because there was no way to predict the severity of the disease in any individual and consequently many Rh negative infants were delivered prematurely only to succumb to respiratory distress syndrome.

Liley, in 1961, described a method of spectrophotometric analysis of amniotic fluid obtained by amniocentesis and correlated optical density values with fetal outcome.[2] With the use of this method he was able to determine which infant would be severely affected and would need pre-term delivery. Of equal importance was the fact that he was also able to conclude which patients could be allowed to continue to term without premature intervention. This new technic, when combined with maternal obstetrical history and selective induction in indicated cases, lowered the perinatal loss from 30 per cent to approximately 10 per cent in affected pregnancies.

In 1963, Dr. Liley reported the first intra-uterine fetal transfusion and proposed this method to further reduce the 10 per cent perinatal mortality.[3] Since then many results have been presented and evaluation of this method continues. Currently it appears that 30 per cent of the infants to which the procedure is applied will have a favorable outcome. The indications for fetal intra-uterine transfusions remain difficult to evaluate, but as experience accumulates hopefully these will become more clear-cut. Our current concept of management of the Rh-negative pregnant patient is outlined in the following paragraphs.

The patients are seen as early in pregnancy as possible, especially if they have had a previously sensitized infant. A complete history is taken regarding blood transfusions, injections of blood or blood products, and any operations are noted that may have required blood transfusions. The duration of gestation and pre-term induction of previous pregnancies is carefully discussed and a history of jaundice, exchange transfusion, or blood transfusion in the infant is noted. Serologic and hematologic data (Coombs titer, bilirubin, hematocrit, blood type and Rh) of infants is obtained if available. It is also important to obtain an accurate history of the last menstrual period preceding this pregnancy and the quickening date is established, since these are very important in the future timing of amniocentesis and delivery.

A physical examination is performed and the pelvic examination should confirm the duration of gestation. If the patient is seen early enough, initial detection of fetal heart tones can also be helpful.

Laboratory data include a complete blood count, serology, and a screen of maternal blood for antibodies. If antibodies are present, they are identified and an antibody titer is performed. We consider the antibody screen and titers to be extremely important and these are checked in all Rh-negative patients in each trimester. If the screen remains negative or the titers are weakly positive, no further interference

The Authors

- Dr. Witmer, Columbus, is Senior Assistant Resident, Department of Obstetrics and Gynecology, The Ohio State University Hospitals.
- Dr. Rigsby, Columbus, is Assistant Professor in Obstetrics and Gynecology, and a member of the Rh Immunization Team, College of Medicine, The Ohio State University.
- Dr. Robertson, Columbus, is Associate Professor in Pediatrics, College of Medicine, The Ohio State University.
- Dr. Thorne, Columbus, is Assistant Professor in Pathology, College of Medicine, The Ohio State University.

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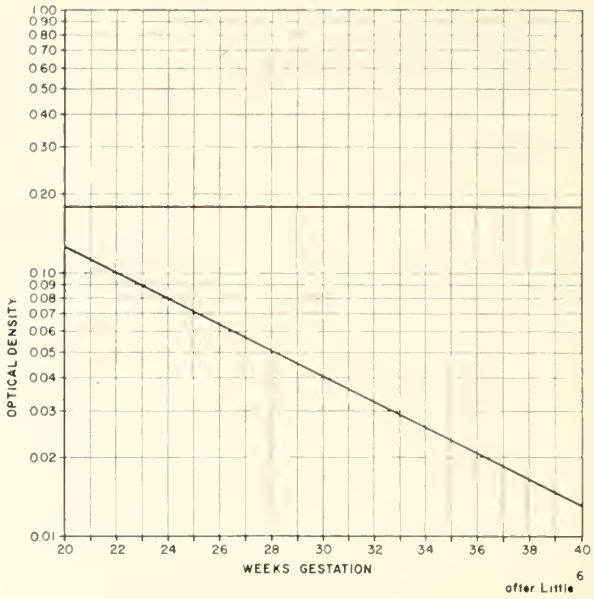
is necessary and the pregnancy is allowed to proceed to term. We have never seen an infant seriously affected if the antibody titer in our laboratory is less than 1:32 (indirect Coombs). An antibody titer of 1:32 or greater is an indication for amniocentesis. A specimen of paternal blood is also examined to establish zygosity of the father for the D antigen.

A patient with a previously affected infant and/or significant antibody titers must be followed with amniocenteses. If the infant was serologically affected but required no exchange transfusion, the initial amniocentesis is performed at approximately 26 to 28 weeks gestation. If the previous infant was more severely affected or required an exchange transfusion, the first amniocentesis is performed at approximately 24 to 26 weeks gestation. In cases of severe Rh disease prior to 34 weeks gestation or a previous perinatal death, amniocentesis is initiated at 20 weeks gestation. Recommendations for timing amniocentesis are summarized in Table I.

Amniocentesis has been described and, with the necessary sterile precautions, is a safe procedure that can be performed on an outpatient basis. The amniotic fluid is collected in a sterile low actinic container, centrifuged, filtered, and the fluid subjected to spectrophotometric analysis. Exposure of this fluid to light alters the optical density readings, so it must be collected in a protected area and put immediately into a low actinic container. The optical density values are plotted over the 300-650 millimicron wavelengths and the peak at 450 millimicrons is determined from a base line as described by Liley.[2] These values are plotted on a graph which is divided into three zones (Graph I). If the value falls in Zone One, it reassures us that the current affliction is mild or nonexistent. We recommend that these patients be tapped in two to four weeks, and if the trend confirms our initial findings, the pregnancy is allowed to proceed to term. An optical density falling in Zone Two indicates mild to moderate sensitization and follow-up amniocentesis at intervals of one to two weeks is indicated to determine the progress of the disease. Decreasing optical density readings indicate that the infant is less severely affected, and the pregnancy can be allowed to progress. Rising optical density values, on the other hand, may indicate the need for fetal intra-uterine transfusions or pre-term delivery. It should be emphasized that we believe serial optical density readings are a necessity in following the progress of this disease. A single reading gives us information only for the ensuing 10 to 14 days and patients in Zone Two must have amniocentesis repeated at this interval and be re-evaluated after each. Most of our patients in Zone Two have been tapped four or more times during their pregnancies.

TABLE 1. *Timing of Initial Amniocentesis*

	Obstetrical History	*First Amniocentesis*
1.	No affected infant—Antibody titer 1:32	28 weeks
2.	Mildly affected infant—Born after 37 weeks	26 weeks
3.	Severely affected infant—Born 34-37 weeks	24 weeks
4.	Severely affected infant—Born before 34 weeks or Intra-uterine fetal death	20 weeks



GRAPH 1. *This chart is used to plot the course of each patient who has had an amniocentesis. The area above the heavy horizontal line at 0.18 O.D. is ZONE THREE. The area below the horizontal and above the oblique line is ZONE TWO and the area below the oblique line is ZONE ONE.*

Patients with optical density values in Zone Three after 34 weeks gestation should be delivered immediately. These infants may be small but are viable, and we consider the risk of intra-uterine transfusion to be greater then the dangers of prematurity. Patients who are between 28 and 34 weeks gestation and in Zone Three are candidates for intra-uterine fetal transfusion. These infants can be given several transfusions to carry them to approximately 34 weeks gestation when delivery can be carried out. This involves a limited number of transfusions and thus the chance of success is greater for patients in this group.

The patients falling in Zone Three prior to 28 weeks present the most difficult problems in management. The data upon which the lines of Graph I are based were derived from patients at 28 weeks gestation or greater. Normal values in the earlier gestational period are not numerous and the decision regarding transfusion in these patients must be carefully considered with all factors taken into account. The infants in this group are often more severely affected, and therapy involves a greater number of transfusions. This is true because of the longer period until 34 weeks gestation and because the in-

fants with smaller blood volumes must be given smaller quantities of blood in each transfusion.

The value of an Rh team is particularly evident in such cases. This team consists of members from the various departments concerned in the total care of the mother and infant and meets weekly to discuss each patient. These sessions are also devoted to discussion of current methods of therapy from other centers and incorporating changes into our therapeutic program.

At The Ohio State University Hospitals we have performed 25 intra-uterine transfusions on 10 patients. Four infants have been born alive and are technical successes: however, two of these infants were severely affected and died of pulmonary difficulties within the early neonatal period. Only two of these patients can be claimed as therapeutic successes, and one of these is now living and well, the regular follow-up at one year revealing normal development. A second infant survived the Rh problem but in addition had associated congenital anomalies, which included an A-V communis defect and Hirschsprung's disease. This infant developed intestinal obstruction and died following an operation at 25 days of age.

The overall success rate of intra-uterine transfusion has been reported as 30 per cent in the Ross Symposium, where nationwide results were reviewed.[4] Involved in this survival figure is the ever present threat to the infant of the transfusion itself. This same symposium placed the mortality rate of each intra-uterine transfusion at approximately 15 per cent. This figure represents direct trauma to the infant as well as possible but infrequent intra-uterine infection or premature onset of labor. When it is considered that severely affected infants may require three or four transfusions for the disease to be adequately treated, the chances of success seem limited. Another reason for the low survival rate is that many of these infants become hydropic at any early age. It is for this reason that amniocentesis is recommended early in pregnancy, if the maternal history suggests severe affliction. It is generally accepted that hydropic infants can rarely be saved through intra-uterine fetal transfusions, and some centers even suggest that the hydropic infant is a contraindication to the procedure.

We feel that our success rate of 20 per cent reflects the fact that many patients were first seen at the stage of gestation when fetal hydrops was already present. The only hope for patients who have had previous severely affected infants or intra-uterine fetal deaths is early obstetrical care, early amniocentesis, and intra-uterine transfusions as indicated. The risks of such transfusions are considerable and are done only when our Rh team concludes this is the only chance for fetal salvage.

The ultimate control of Rh disease hopefully lies in the work now being done with the anti-Rh gamma globulin. Freda et al[5] have summarized experience with the use of 5 cc of anti-Rh gamma globulin given to the unsensitized Rh negative patient within 72 hours after delivery of an Rh-positive infant. Three hundred and twenty-nine patients have received this immunization, and none of these patients has become sensitized in her next pregnancy. This same immunization was given following delivery of the second Rh-positive infant and, of this number, 31 have given birth to a third child. Within this protected group, there have been no sensitizations and no affected infants. This method is being further evaluated, and reduction of the total dose of gamma globulin is being attempted since the supply is both limited and expensive. This procedure promises to be the eventual answer to the Rh problem but will require the active participation of every obstetrical unit. It is emphasized that this method is currently applicable only to nonsensitized mothers.

Meanwhile we must continue to apply our present methods as best we can to the sensitized Rh patient. As mentioned earlier, the most important factor is early obstetrical care. Patients with a history of Rh disease should be seen as early as possible and antibody titers drawn. If these are 1:32 or greater, arrangements should be made for amniocentesis. With the progression of the fetal disease established early, it is possible to utilize intra-uterine transfusions before the infant becomes hydropic. Although intra-uterine fetal transfusion is not a panacea, it is a useful tool that seems safe for the mother and offers severely affected infants their only chance for survival.

Summary

Significant developments in erythroblastosis fetalis have been reviewed. Current management of the Rh sensitized patient and the results of intra-uterine fetal transfusions at The Ohio State University Hospitals are presented. The promise of anti-Rh gamma globulin in the treatment of Rh disease is recognized.

Acknowledgment: Our sincere thanks to other members of the Rh team who have participated in the care of our patients—Elizabeth Ruppert, M.D., Inta Ertel, M.D., William Molnar, M.D., Betty McDaniels, Ann Marson, Kay Ryan, and Rosita Aguirre.

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Azotomia and Oliguria Associated with Kanamycin Therapy

Report of a Case in a Newborn Infant With Congestive Heart Failure

DANIEL K. BLOOMFIELD, M.D., DANIEL SHAPIRO, M.D., and VICTOR VERTES, M.D.

THE ANTIBIOTIC kanamycin has been found to be relatively free from toxic side effects. Ototoxicity is well documented[1, 2] and a milder nephrotoxicity has been noted.[3-5] We are reporting a case of nonspecific respiratory illness in a newborn infant, who was treated with kanamycin and who developed an alarming degree of oliguria and azotemia which reversed when kanamycin therapy was stopped.

Case Report

Six hours after birth this infant developed respiratory distress with dyspnea, rib retractions, and cyanosis. X-ray films of the chest showed marked pulmonary congestion and probable cardiomegaly (Fig. 1). The patient was assumed to have suffered from meconium aspiration and congestive heart failure. She was treated with digitalis and kanamycin 15 mg. per kg. daily in divided dosage, and penicillin 100,000 units twice a day and was given 10 per cent glucose in water intravenously through the umbilical vein. Over the next three days the patient's lungs cleared (Fig. 2), but she failed to begin a normal postnatal diuresis nor was there a significant fall from birth weight (Fig. 3). On the second and third day of life the nurses noted the patient was voiding in-

From the Department of Medicine and Pediatrics of Mt. Sinai Hospital of Cleveland.

Submitted August 8, 1967.

The Authors

- **Dr. Bloomfield, Cleveland, is Senior Clinical Instructor in Medicine, Case Western Reserve University.**
- **Dr. Shapiro, Cleveland, is Clinical Instructor in Pediatrics, Case Western Reserve University.**
- **Dr. Vertes, Cleveland, is Assistant Clinical Professor in Medicine, Case Western Reserve University.**



FIG. 1. *PA chest x-ray on first day of life showing diffuse pulmonary infiltrate and probable cardiomegaly.*

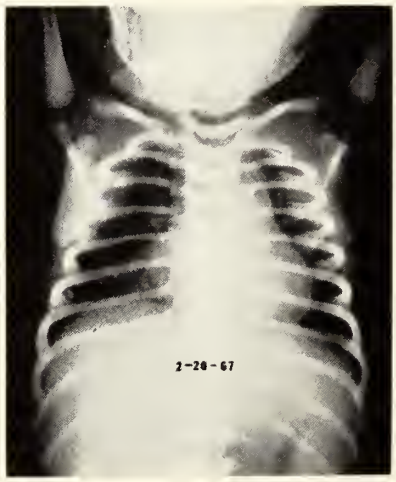


FIG. 2. *PA chest x-ray on the third day of life showing marked clearing. This x-ray is now within normal limits.*

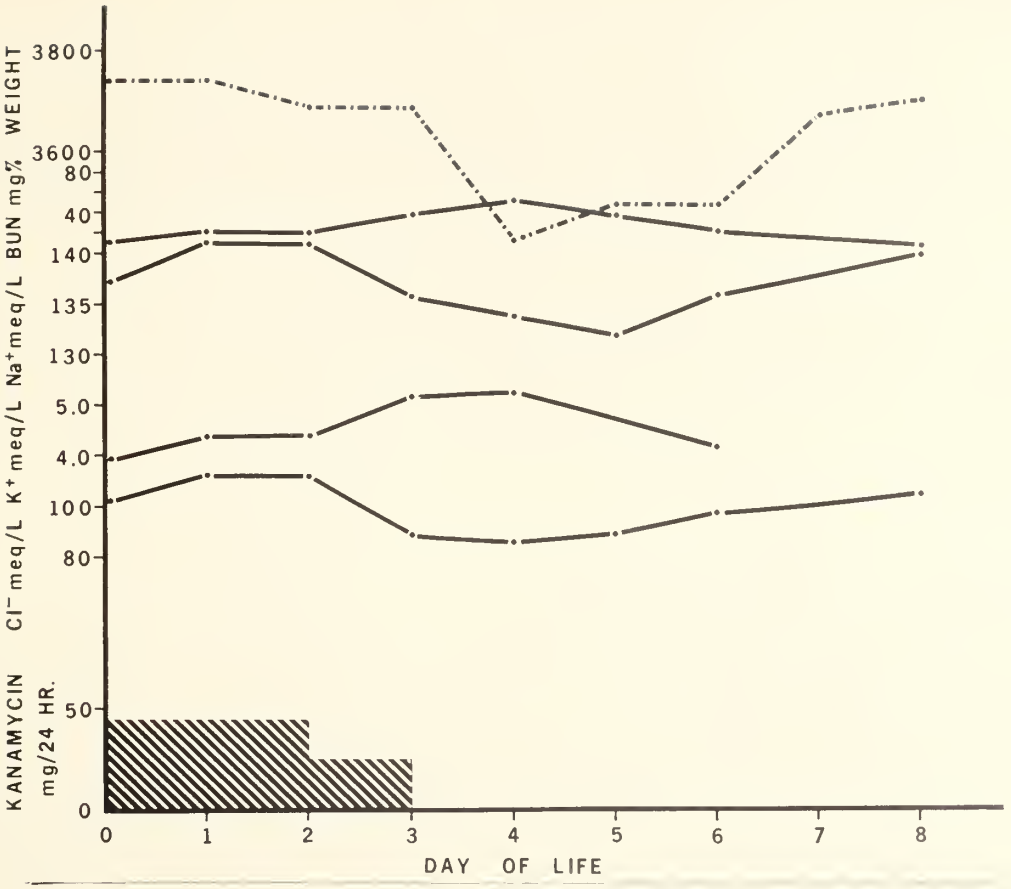


FIG. 3. *Summary of weight and electrolytes.*

frequently and diaper urine was noted only once or twice per 24 hours. The BUN rose to 43 on the third day of life and to 56 the next day. Urinalysis on the fourth hospital day showed specific gravity 1.007 with 9 to 12 red cells per high power field, and one to two white cells per high power field in the sediment. Changes in serum electrolytes are shown in Fig. 3. On the third hospital day the kanamycin was discontinued and within 24 hours there was a marked increase in urinary output indicated by 12 diaper changes daily and a concomitant fall in body weight. At the same time the patient's appetite improved and fluid intake rose from 300 cc. per day to 720 cc. per day. When kanamycin therapy was stopped the patient was treated with Similac® supplemented by intermittent feedings of 5 per cent dextrose and saline. Six days later the patient appeared normal and was feeding well. She was no longer azotemic and had a normal urine except for 8 to 11 white blood cells in the urinary sediment.

Discussion

It cannot be stated categorically that the oliguria and azotemia were due to kanamycin therapy. Although the pulmonary and cardiac status cleared in advance of discontinuing kanamycin, significant urine and electrolyte improvement did not occur until kanamycin was discontinued. Eichenwald[5] has noted nitrogen retention occurring rarely with maximum levels not rising above 35 mg. per 100 mls. and returning to normal within three to four days after discontinuation of the drug. The more significant toxicity seen in this case was in part due to the initial cardiopulmonary insult, which probably reduced renal excretion and exaggerated levels of kanamycin. It is noteworthy that signs of nephrotoxicity reversed promptly when the kanamycin was discontinued.

Supported in part by Research Grant HE 07308 from the National Institutes of Health, U. S. Public Health Service.

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Acute Renal Failure Complicating Pregnancy

Report of a Case Successfully Treated with Hemodialysis

WALTER A. KEITZER, M.D., J. WEGRYN, M.D., and BIRENDRA TANDAN, M.B., B.S.

ALTHOUGH we have used hemodialysis[1] since 1950 for treatment of renal failure due to a variety of causes, we have had very little experience using hemodialysis in pregnancy. A case in which such an opportunity was offered is reported. We believe this to be the fourth reported case of fetal survival in acute renal failure complicating pregnancy.

The incidence of fetal mortality in pregnancy with acute renal failure is very high,[4,5] although there have been scattered reports in literature[2,3,4] where pregnant females have undergone hemodialysis for acute or chronic renal failure. The cases reported by Theil, et al[2] and Kurtz et al[4] were patients with acute drug poisoning, and the case reported by Soyannwo et al[7] had electrolyte imbalance. Our case suggested a hemolytic process.

Case Report

A 19 year old Negro woman, gravida 1 para 0, was admitted to the Intensive Care Unit of Akron City Hospital on April 24, 1966, with complaints of swelling of both feet and legs, gradual weakness, and reduction in the amount of urine for the past 10 days. Her last menstrual period was Sept. 14, 1965. There was no significant past history. Physical examination revealed slight but generalized anasarca, respiratory rate 20 per minute, temperature 99 F, and blood pressure 150/110 mm of Hg.

The pupils were round, equal in size, and reacted to light and in accommodation. The ocular fundi were normal bilaterally. Crepitant rales were heard at both lung bases. A soft systolic murmur was heard only at the apex. Liver, spleen, and kidneys were not palpable. The uterus was palpable 2 cm above the umbilicus. Fetal heart rate was 110 per minute. The patient weighed 143 pounds.

On admission hemoglobin was 9.8 gm. per 100 cc, hematocrit 28 per cent, and polychromasia basophilic stippling and numerous nucleated red cells were observed in the peripheral smear. Thrombocyte count was 220,000 per 100 cc and reticulocyte count 3 per cent. Coomb's test was positive. Report of blood chemistries were as follows: serum bilirubin 3.4 mg. per 100 cc, blood sugar 80 mg. per 100 cc, BUN 106 mg. per 100 cc, serum creatinine 18.2 mg. per 100 cc, sodium 142 mEq. per liter, potassium 4.8 mEq. per liter, chloride 97 mEq. per liter, Co_2 27 mEq. per liter, and phosphorous 3.48 mEq. per liter. Urinalysis showed specific gravity of 1.015, albumin one plus, and numerous red blood cells per high power field. Serum osmolality was 314 milliosmols, and urine osmalality 303 milliosmols. A chest x-ray revealed congestion of both lung fields and slight cardiomegaly.

Our working diagnosis was acute hemolytic process causing acute renal failure. She was managed with hourly urinary output monitored by a Foley catheter, prednisone 80 mg, and a total intravenous fluid intake of 500 cc of 10 per cent dextrose in water on the first day of admission. The total urinary output for the first 24 hours was 85 cc which rose to 188 cc in the second 24 hour period. However, her general condition deteriorated with the development of dyspnea, respiratory rate of 30 per minute,

The Authors

- **Dr. Keitzer, Akron, is Chairman of the Department of Urology, Akron City Hospital.**
- **Dr. Wegryn, Akron, is a member of the staff of the Department of Urology, Akron City Hospital.**
- **Dr. Tandan, Akron, is Senior Resident in the Department of Urology, Akron City Hospital.**

From the Department of Urology, Akron City Hospital.
Submitted August 8, 1967.

pulse rate of 100 per minute, and blood pressure 170/100 mm of Hg.

On the second day (April 25, 1966), with no further improvement, cystopanendoscopy and retrograde pyelography were performed under local anesthesia, revealing normal urinary collecting system with no obstruction. On the third day, hemodialysis was performed with cannulas in the right radial artery and a large forearm vein, using a standard disposable twin coil, Kolff artificial kidney. The coil was primed with 1000 cc of fresh whole blood with 30 mg of heparin added and 20 mg more given after two hours. Clotting time of patient's blood was checked every hour and maintained at 30 minutes. The total dose of heparin given was 100 mg. Protamine 50 mg. was given intravenously after termination of dialysis. The rate of blood flow through the dialyzer was 320 cc per minute. The coil pressure was maintained between 160 and 180 mm of Hg. The total length of dialysis was 4 hours and 20 minutes during which the patient received 800 cc of whole blood. Her blood pressure remained between 160 and 180 mm of Hg systolic and 100 and 110 mm of Hg. diastolic throughout the procedure. Fetal heart rate ranged between 90 and 100 per minute. There were no uterine contractions. The post dialysis BUN was 29 mg per 100 cc, creatinine 9.1 mg. per 100 cc, sodium 147 mEq. per liter, potassium 4.6 mEq. per liter, chloride 103 mEq. per liter, CO_2 27 mEq. per liter, calcium 7.2 mg per 100 cc, phosphorus 2.1 mEq. per liter, magnesium 2.6 mEq. per liter.

About two hours after the dialysis, a bloody discharge was noticed in the vagina, and the patient experienced labor pains. After about 3 hours and 45 minutes of labor a 2 lb 12 oz female infant was delivered by spontaneous delivery from L.O.A. position. The infant's cry was weak, and she was immediately transferred to the premature nursery. The placenta revealed ischemic infarction and focal degenerative changes on gross and microscopic examination.

The urinary output of the patient increased from 342 cc on the day of dialysis to 1460 cc 24 hours later with a period of diuresis lasting from the eighth day of hospitalization to the twelfth day when it came down to 1400 cc/24 hours. A urinalysis was within normal limits.

The patient's condition improved gradually but steadily and she was discharged on May 14, 1966, three weeks after hospitalization, with a BUN of 8.6 mg. per 100 cc, creatinine 1.3 mg. per 100 cc, Hb. 8.6 gm. per 100 cc, weight 118½ lbs., and a blood pressure of 146/90 mm of Hg. An intravenous pyelogram was done on May 13, 1966 and was within normal limits. The infant had a BUN of 66 mg. per 100 cc at birth which came down to normal level in 6 days, the weight gain was steady and at the age of 42 days the infant was discharged weighing 5 lb. 1 oz.

Discussion

In general, the prognosis for the mother is guarded though manageable but little is known about the effect of hemodialysis on the fetus. It has been postulated that azotemia and hypertension produce placential ischemia (Tenny and Dandrow),[8] also seen in our patient, which leads to fetal hypovolemia, azotemia, and death. It would thus seem clear that if maternal azotemia can be rapidly countered the fetal mortality can be significantly reduced or even eliminated.

The infants who have survived were usually of 30 to 40 weeks gestation. In the case reported by Kurtz et al,[4] the patient had a relatively short period of azotemia due to glutethimide poisoning and had a post dialysis course of oliguria for 5 days, after a 10-hour dialysis. In our case, the patient went into labor after dialysis, delivered a viable fetus, followed by a rapid course of gradually increasing urinary output and a period of diuresis. The kidney function had returned to near normal in a period of three weeks time. The newborn showed no evidence of azotemia at birth and had a normal BUN at 6 days of age.

We failed to find the reason why our patient went into labor shortly after hemodialysis, although throughout the period of dialysis the fetal heart remained within normal range and there were no uterine contractions. Cases reported hitherto in literature were generally dialyzed late and therefore the maternal mortality as well as the fetal mortality has been high. It is our belief that, although there is much to be learned about hemodialysis during pregnancy, if acute renal failure is recognized early enough, this form of treatment can be used with relative safety and success in pregnant patients.

Summary

A case report of successful use of hemodialysis in the treatment of acute renal failure, complicating pregnancy, is presented. This is the fourth such case reported in literature.

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Heart Page

Peripheral Vascular Disease

III. Medical Management of Chronic Occlusive Arterial Disease

RAY W. GIFFORD, JR., M.D.

THERE ARE two cardinal features in the management of the patient with atherosclerosis obliterans (ASO) or thromboangiitis obliterans (TAO): abstinence from tobacco, and scrupulous care of the ischemic extremities. The patient, if he is a smoker, should be persuaded to stop smoking cigarettes, which are deleterious in both conditions. In addition, all forms of tobacco should be avoided by the patient with TAO, because it appears that hypersensitivity to tobacco may play a role in the etiology of this disease.

Of equal importance to abstinence from tobacco is careful and detailed instruction, both oral and written, in the prophylactic care and hygiene of ischemic extremities. The patient should be impressed with the importance of avoiding mechanical, chemical, and thermal trauma. Prompt treatment of dermatophytosis is imperative. Ingrown toenails, corns, and calluses should be treated by a physician or podiatrist knowledgeable in the hazards of ischemia.

Appropriate dietary modifications are advisable for patients with ASO who also have hypercholesteremia, hypertriglyceridemia or diabetes mellitus, and for obese patients with either ASO or TAO.

For therapeutic and prognostic considerations it is useful to divide the course of chronic occlusive arterial disease into three clinical stages.

Stage 1. When intermittent claudication is the only symptom of chronic occlusive arterial disease the patient should be encouraged to walk to tolerance many times daily, because exercise encourages the development of collateral circulation. Reassurance by the physician is in order, since most patients with chronic occlusive arterial disease fear that amputation is not only inevitable but imminent; whereas, in reality, if they abstain from smoking and practice prophylactic principles, the prognosis is good. Unfortunately, vasodilating drugs and sympathectomy are notoriously ineffective in relieving intermittent claudication; therefore, when the patient cannot learn to live with his intermittent claudication or when it interferes with his earning capacity, a revascularizing operation is indicated.

Stage 2. When pain occurs in the ischemic extremity at rest (see Part I) the prognosis for survival of the limb becomes worse. The patient should stay in bed (with bathroom privileges permitted), preferably in a hospital. If there is no edema of the feet, the head of the bed should be elevated on 8- or 10-inch wooden blocks. Although I have little confidence in vasodilating drugs in the treatment of chronic occlusive arterial disease, I usually prescribe whiskey if the patient can tolerate it, as alcohol is an excellent vasodilator (for normal arteries), and in addition is a good anodyne and sedative as well. Sometimes the use of an oscillating bed and placing the feet in a thermostatically controlled heating unit (80-90 F) help to relieve the pain of ischemia; when pain is aggravated, these measures should be discontinued. It is important to prescribe narcotics, if necessary to control the severe pain, so that the patient is not obliged to keep his ischemic legs dangling over the edge of the bed to get relief. This pernicious practice predisposes to the development of edema, which increases tissue pressure and further compromises the circulation to an already ischemic extremity. Sympathetic nerve blocks or surgical sympathectomy sometimes relieves the rest pain of ischemia. When it is technically feasible (providing that the patient's condition permits), surgical revascularization of the painfully ischemic extremity is preferable to sympathectomy.

Stage 3. When ischemic ulcers and gangrene supervene, the prognosis is dismal. All of the therapeutic measures outlined for treatment of patients in stage 2 are applicable for patients in stage 3, in addition to local care of the ulcers. Cultures should be made from the exudate. When the organisms that are identified are not sensitive to antibiotics that can be safely administered parenterally, I prefer to apply a 1 per cent solution of neomycin topically. The affected foot (or hand) should be immersed in a tepid (never exceeding body temperature) saturated solution of boric acid for 30 minutes three or four times daily. Stringent solutions and ointments should be avoided. When an adherent crust covers the ulcer, I employ enzymatic debridement. When arteriograms reveal that revascularization is not feasible and amputation is inevitable it should be carried out as soon as the patient's condition permits and at the lowest level of the extremity compatible with rapid healing.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

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was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

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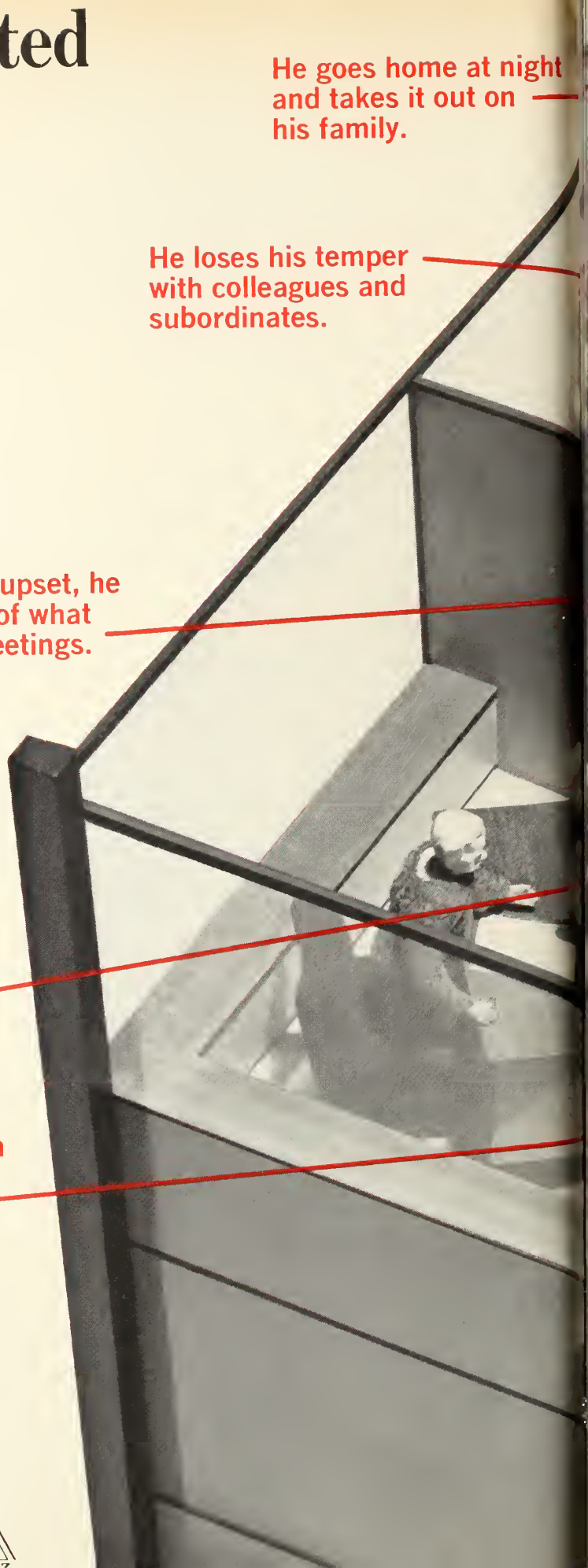
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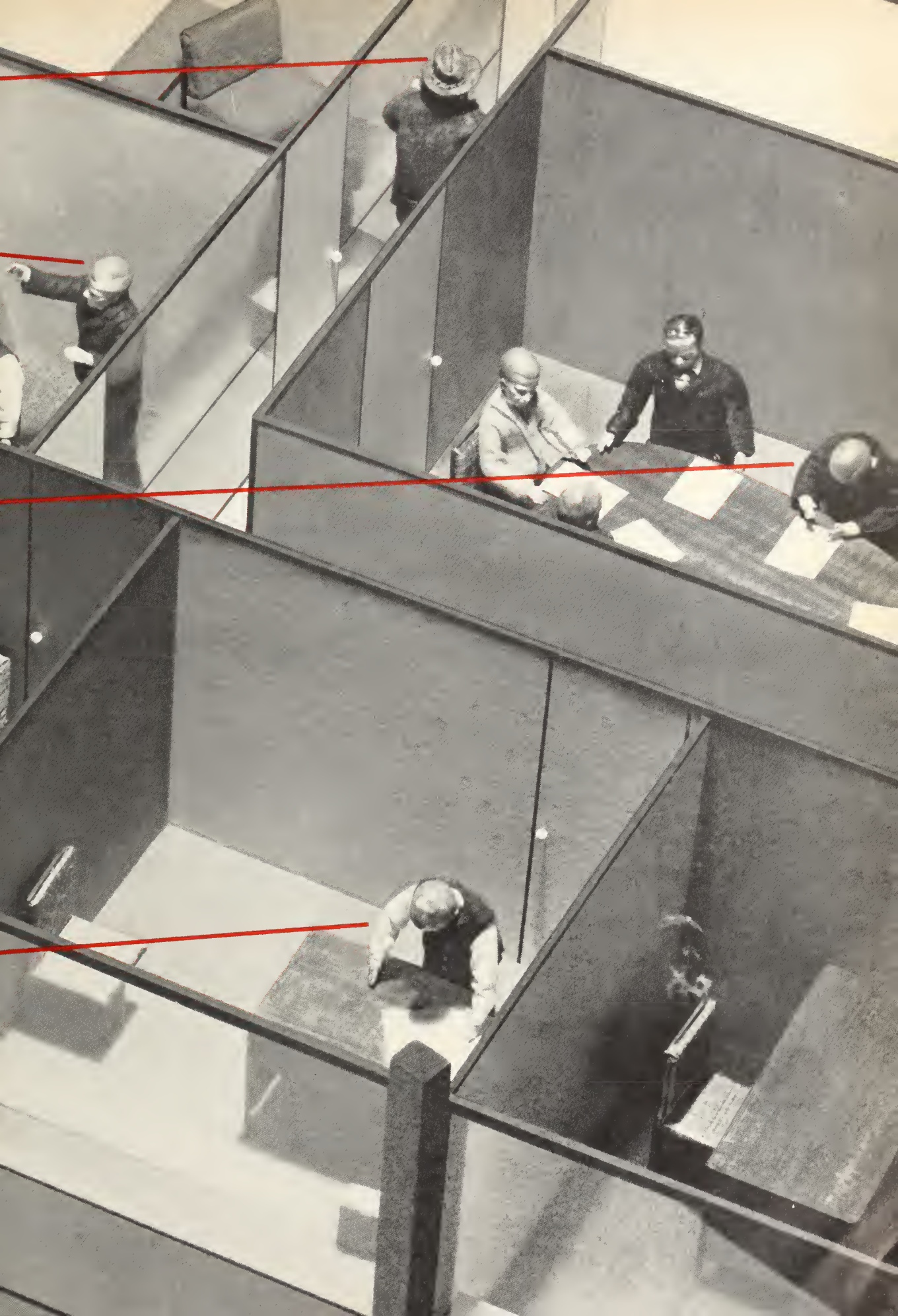
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NEWS AND Organization Section

Proceedings of The Council...

Report of Numerous Matters Considered at December 9 Meeting. With Summary of Actions Taken: Budget for 1968 Is Approved

A MEETING of The Council of the Ohio State Medical Association was held in the headquarters office, Columbus, December 9, 1967. All members of The Council were present except Dr. James L. Henry, Grove City, Treasurer, and Dr. Robert N. Smith, Toledo, Councilor of the Fourth District. Others attending the meeting were: Dr. John H. Budd, Cleveland, chairman, Ohio delegation to the AMA; Dr. Richard L. Meiling, Columbus, delegate to the AMA; Mr. David B. Weihaupt, Chicago, AMA field representative; Mr. Roger Smith, Toledo, OSMA legal counsel; and Messrs. Page, Edgar, Gillen, Campbell, and Moore of the OSMA staff.

Minutes Approved

The minutes of the meetings of The Council held November 4 and 5, 1967, were approved by official action.

Membership Statistics

The Executive Secretary reported on membership statistics as follows: OSMA membership as of December 7, 1967, was 10,122, compared to a total membership of 10,072 on December 7, 1966, and 10,096 on December 31, 1966. Of the 10,122 members, 8,844 were affiliated with the AMA.

Ad Hoc Committee Appointed

The President appointed an ad hoc committee to study membership and membership statistics. Members of the committee are: Dr. William R. Schultz, Wooster, chairman; Dr. T. L. Light, Dayton, and Dr. Richard L. Fulton, Columbus.

Reports by Councilors

The Councilors reported on activities in their districts.

Report on AMA Meeting

Dr. Budd reported for Ohio's AMA delegation to the clinical session in Houston. He announced that the Committee on Future Planning was set up as a result of Ohio's resolution and that the following were appointed to the committee: George Himler, M. D., New York, chairman; John H. Budd, M. D., Cleveland; George B. Hubbard, M. D., Jackson, Tennessee; John H. Knowles, M. D., Boston; Eugene S. Rifner, M. D., Van Buren, Indiana; Malcolm Stuart M. Watts, M. D., San Francisco; and W. Clarke Wescoe, M. D., Lawrence, Kansas. A summary of Dr. Budd's report appeared on pages 79 and 80 of the January issue of *The Journal*.

Due to the fact that Ohio will have one less delegate and one less alternate to the AMA beginning January 1, 1968, The Council was asked to determine the method of election at the meeting of the House of Delegates, May 16, 1968. The Council expressed the opinion that open candidacy for the four positions would be the proper method of election.

The Council expressed the opinion that all AMA field representatives should attend the clinical and annual sessions of the AMA House of Delegates, and

asked that the President transmit this expression to Dr. F. J. L. Blasingame, Executive Vice-President of the AMA.

Dr. Meiling reported on the progress of the campaign for Dr. Lincke, Carrollton, for the vice-presidency of the American Medical Association. Dr. Meiling noted the increasing importance of this office due to the fact that the Vice-President would serve as President in event of the death or disability of the President of the AMA, and that under a new amendment to the Constitution and Bylaws the Vice-President is granted the right to vote in the deliberations of the Board of Trustees of the AMA.

At Dr. Meiling's suggestion, The Council approved the development of a resolution to be presented by the Ohio delegation, requesting that interim sessions of the AMA House of Delegates be held in Chicago, and that a request for economy of operation be tied in with this resolution.

1968 County Society Officers Conference

Mr. Edgar outlined plans for the County Society Officers Conference to be held February 25, 1968, in Columbus. The Council approved the following program outline:

MORNING PROGRAM
Dr. Howard, Presiding

9:00 Welcome — Dr. Howard
9:10 "What Has the AMA Ever Done for You?" — Dave Weihaupt
9:20 Questions and Answers
9:30 Medical Ethics and Reasonable Fees — Dr. Petznick
9:50 Questions and Answers
10:00 Public Law 749 — Comprehensive Health Planning in Ohio — Sewall Milliken
10:30 Questions and Answers
10:50 The Ohio State Medical Board — Dr. Washam
11:10 Questions and Answers
11:20 Your Ohio Delegation to the AMA Reports — Dr. Budd
11:40 Questions and Answers
11:50 Complimentary Luncheon

AFTERNOON PROGRAM
Dr. Light, Presiding

1:15 OSMA Policies Regarding Government Medical Care Programs — Dr. Porterfield
1:25 Questions and Answers
1:35 Councilor District Conferences
2:50 The 1968 OSMA Annual Meeting — Special Features — Dr. Howard

It was suggested that reprints of the OSMA statement on the government medical care programs be made available for distribution at the meeting, and that a written report on Ohio Medical Indemnity, Inc., and OSMA relations be available for distribution at the Councilor District meetings.

Financial Report

The Council, in executive session, then considered a report of the Committee on Auditing and Appropriations, presented by the chairman, Dr. William R. Schultz, Wooster. The report of the committee, including a budget for 1968, was approved by official action.

BUDGET FOR 1968

The Ohio State Medical Journal	$ 40,000.00
Organizational State Salaries and Expenses	98,500.00
Public Relations — Information Materials	1,000.00
Public Relations — Miscellaneous Activities	10,000.00
Stenographic and Clerical Salaries (Includes Military Adv. Chmn.)	69,120.00
President: Expense $4,500; Honorarium $4,000	8,500.00
President-Elect: Expense $3,500; Honorarium $2,000	5,500.00
Council, Expense	10,000.00
American Medical Association Delegates-Alternates (Includes Annual Delegates' meeting.) (Per diem rate: $35.00)	21,000.00
Committees:	
Education	$ 600.00
Judicial and Professional Relations	600.00
Public Relations and Economics	400.00
Scientific Work	1,000.00
Auditing and Appropriations	1,500.00
Cancer	350.00
Disaster Medical Care	500.00
Environmental and Public Health	1,000.00
Eye Care	300.00
Government Medical Care Programs	2,000.00
Hospital Relations	1,500.00
Laboratory Medicine	400.00
Maternal Health	2,000.00
Medicine and Religion	200.00
Mental Health	1,300.00
Rural Health	1,800.00
School Health	2,500.00
Workmen's Compensation	500.00
Annual Meeting	35,000.00
Conference of County Society Officers	3,000.00
Councilor District Conferences	5,000.00
Emergency Fund	4,000.00
Employees' Retirement Fund	20,000.00
Insurance and Bonding (Blue Cross-Blue Shield, disability, general coverage officers, staff, fire, theft "umbrella" etc.)	$ 6,500.00
Taxes (Social Security, Ohio and Fed. Unemployment, Workmen's Comp., Industrial Commission, State Excise Tax)	7,000.00
Lectures for Medical Students	3,000.00
Legal Expense	14,000.00
Library	300.00
OSMAgram	7,500.00
Postage	8,500.00
Professional Relations Activities	15,000.00
Rent	21,465.00
Rural Medical Scholarships	4,000.00
Stationery, Printing, Supplies	9,000.00
Telephone and Telegraph	6,500.00
Total	$451,835.00

1968 Annual Meeting

Mr. Campbell reported on the progress of plans for the 1968 OSMA Annual Meeting to be held in Cincinnati, May 13 - 17.

OMI Coverage

A letter from Dr. William B. Schwartz, Columbus, dated October 18, 1967, was presented to The Council. This communication requested that OMI have Blue Shield coverage for diagnostic, laboratory and x-ray work expanded in all of their contracts to cover these services on an outpatient basis.

The Council voted to forward to Ohio Medical Indemnity, Inc., through the OSMA-OMI Liaison Committee, the communication from Dr. Schwartz, with the suggestion of The Council that this request be given prompt and serious consideration.

Government Medical Programs

It was announced that Dr. Richard L. Fulton, Columbus, has been asked to serve as Columbus chairman for the heart, cancer, and stroke program. This program is being coordinated in 61 counties of Ohio by Dr. Neil Andrews, Columbus.

Ohio Valley Health Service Foundation, Inc.

Dr. Clarke announced that the Ohio Valley Health Service Foundation, Inc., has a practicing physician from each county on its board of directors and that Dr. W. T. Washam is on the executive committee.

Federal Legislation

Mr. Edgar reported the following developments on H. R. 12080: Substitution of itemized bill instead of receipted bill; removal of certification of necessity for hospital admission (Title 18) and guarantee of free choice of physician (Title 19). Mr. Edgar reported that the final outcome of the bill would not be known until the report of the Senate-House Joint Conference Committee was accepted by the Senate and House.

OSMA Billing Form

A draft of a proposed OSMA billing form for third parties was presented to The Council. Members of The Council were asked to study the form and send their suggestions to the headquarters' office.

1968 Washington Visitation

Mr. Weihaupt announced that late May or early June would be favorable periods for the annual Washington visitation of the OSMA officials with Ohio Congressmen. The President appointed Dr. Light to work out the dates with the staff, Mr. Weihaupt, and the AMA Washington office.

Self-Medication Practices in Columbus

A letter from David A. Knapp, Ph. D., associate professor and project director, Community Health Research Group, Ohio State University, regarding a study of self-medication practices in the Columbus area, was referred to the Columbus Academy of Medicine.

Committee Reports

Title 19 Subcommittee

Mr. Edgar reported on a meeting of the Title 19 Subcommittee of the OSMA Committee on Government Medical Care Programs held November 15, 1967. Approval of the report carried with it the approval of a recommendation of the subcommittee that every avenue of approach be used to obtain an early and meaningful audience with the Governor and his staff to seek an early solution to the problems.

Ohio Cancer Coordinating Committee

Mr. Gillen reported on a meeting of the Ohio Cancer Coordinating Committee held November 12, 1967.

The Council disapproved a section of the minutes which would have asked the American College of Surgeons to request the Joint Commission on Accreditation of Hospitals to make accreditation of a hospital contingent upon having a cancer program which has the approval of the American College of Surgeons.

With regard to another section of the report, which recommended that Council consider the suggestion of 11 ACS's regional liaison fellows be members of the Ohio Cancer Coordinating Committee, Inc., The Council expressed the opinion that it was not advisable to add to the membership of this committee, but that some coordinating action by the committee with the regional liaison fellows might be indicated.

The remainder of the report was approved, including a recommendation that the Ohio Association of Osteopathic Physicians and Surgeons and the Ohio Osteopathic Hospital Association be invited to become members of the Ohio Cancer Coordinating Committee, Inc.

Mental Health Committee

Mr. Gillen reported on a meeting of the Committee on Mental Health held November 19, 1967. In approving the minutes, The Council endorsed the committee's decision to offer the program "The Many Faces of Depression" to county medical societies and to the program committees and officers of those in charge of district medical society postgraduate programs.

Council also approved the suggestion that a subcommittee of the Committee on Mental Health meet with the subcommittee of the Committee on Government Medical Care Programs to study and analyze House Bill 648, the Community Mental Health Services Act, make recommendations regarding objectionable features and arrange for a conference with those who are writing the rules and regulations by

which the act will be administered to request necessary changes.

The Council **approved** the reaffirmation of the OSMA position of many years that the Department of Mental Hygiene and Correction should be separated; the committee's suggestion that the Legislative Service Commission be encouraged to conduct a comprehensive study of the field of mental hygiene in this state, and the committee's agreement to provide testimony in support of a study in the separation, if such a study is undertaken.

In regard to a new organization known as the Alliance for Mental Health, The Council deferred action on the question of participation in such organization until a report of the steering committee of the Alliance is available for study and consideration.

The Council **approved** the committee's action to implement Resolution No. 8 (OSMA House of Delegates, 1967, mental health centers) as follows:

1. Instructed staff to determine what has already been developed in this area;
2. Authorized development of guidelines for county medical societies;
3. Offered consultation services where centers are to be planned;
4. Instructed staff to develop liaison with the Department of Mental Hygiene and Correction; and
5. Asked consultation and assistance from the AMA Committee on Mental Health.

Committee on Disaster Medical Care

Mr. Campbell reported on the meeting of the Committee on Disaster Medical Care held December 3, 1967. Included in the recommendations of the committee **approved** by The Council was a suggestion that each emergency medical care district spokesman organize and hold a meeting in his district. The report of the committee presented guidelines for these meetings.

Committee on Redistricting

Dr. Ivins presented a progress report of the Committee on Redistricting which met November 3, 1967. Dr. Ivins said he anticipates that a workable district plan will be presented to The Council at its meeting.

Committee on Workmen's Compensation

Mr. Campbell discussed current matters regarding workmen's compensation. It was the expression of The Council that the Bureau of Workmen's Compensation should check with the physician involved with regard to routine matters between the Bureau and the individual physician. If the question cannot be resolved in this manner and the bill is questionable, then it should be channeled to the OSMA and district Councilor. Officers and staff of the Association were requested to discuss this suggestion with the administrator of the Bureau.

The Ohio State Medical Journal

Mr. Moore reported on the 1967 operation of *The Ohio State Medical Journal.* Mr. Moore's report was in writing and it was accepted for the information of The Council.

Blue Cross of Northeast Ohio

The following statement concerning action of the Blue Cross of Northeast Ohio **was approved** for circulation, with the request of The Council that appropriate sections of the AMA Principles of Medical Ethics be incorporated into the report:

> In February of 1967 Blue Cross of Northeast Ohio endeavored to amend its contracts with hospitals whereby hospital medical staffs would audit or review professional fees of hospital-based physicians.
>
> This matter was brought to the attention of The Council at its meeting February 18-19, 1967, and The Council adopted the following policy statement:
>
> "It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted County Medical Society committee of his peers may appropriately review and pass upon the equity and justice of his charge. It is not proper for hospital management nor a hospital medical staff nor any insurer nor any hospital service association to attempt to exercise this function.
>
> "Neither the hospital management nor the hospital medical staff nor any insurer nor any hospital service association has the privilege or the right to demand an audit of staff members' personal financial records for any purpose. Any attempt on the part of the medical staff to compel such audit is unethical."
>
> On September 8, 1967, Mr. Vernon R. Burt, Executive Vice-President, Blue Cross of Northeast Ohio, addressed a letter "To All Hospitals with Which Blue Cross Contracts." Attached to the letter was a document entitled "Program for the Implementation of the Waiver of Ceilings on Professional Components."
>
> The program was described in its initial paragraph as "committing the hospital to review the cost or use of certain services, *** "The services are described as "the professional component of the services of radiology, pathology, cardiography or electroencephalography ***"
>
> The proposal would provide, by contract, that the hospital medical staff and/or the Blue Cross medical advisory committee review the professional charges of these physicians.
>
> A copy of the proposal is attached.

Recommendation: It is recommended that The Council instruct that a letter be sent to all County Medical Society presidents, secretaries, executive secretaries and ethics committee chairmen of those counties in the NEOBC area, and the Plan's Medical Advisory Committee, such letter to reiterate the policy statement of February 18-19, 1967, and that the policy statement be amended to include the following citation from the Ohio Medical Practice Act:

"Section 4731.22. The state medical board, by a vote of not less than five of its members, may refuse to grant a certificate to a person guilty of fraud in passing the examination, or may revoke or suspend a person at any time guilty of felony or gross immorality, grossly unprofessional or dishonest conduct, or addicted to the liquor or drug habit to such a degree as to render him unfit to practice medicine or surgery.

" 'Grossly unprofessional or dishonest conduct' as used in this section means:

"(A) The employing of any capper, solicitor, or drummer for the purpose of securing patients, or subsidizing any hotel or boardinghouse with like purpose, or the obtaining of any fee on the assurance that an incurable disease can be cured;

"(B) The willful betrayal of a professional secret; but a physician, knowing that one of the parties to a contemplated marriage has a venereal disease, and so informing the other party to such contemplated marriage, or the parent, brother, or guardian of such other party, shall not be held to answer for betrayal of a professional secret nor shall such physician be liable in damages for truthfully giving such information to such other party, or the parent, brother, or guardian of such other party;

"(C) All advertising of medical practice in which extravagantly worded statements intended, or having a tendency to deceive and defraud the public are made, or where specific mention is made in such advertisements of tuberculosis, consumption, cancer, Bright's disease, kidney disease, diabetes, or of venereal diseases or diseases of the genito-urinary organs;

"(D) Having professional connection with, or lending one's name to an illegal practitioner of medicine;

"(E) Any division of fees or charges, or any agreement or arrangement to share fees or charges, made by any physician or surgeon with any other physician or surgeon, or with any other person.

"(F) The violation of any provision of a code of ethics of a national professional organization as specified in this division. 'National professional organization' means the American Medical Association, the American Osteopathic Association, the American Chiropractic Association, the American Podiatry Association, and such other national professional organizations as are determined, by rule, by the state medical board. The state medical board shall obtain and keep on file current copies of codes of ethics of the various national professional organizations. The practitioner whose certificate is being suspended or revoked shall not be found guilty of the violation of a code of ethics of an organization not appropriate to his profession."

Athletic Injuries

Dr. Press presented the following statement with regard to safety factors to be considered in regard to participation in competition by high school students. The statement was referred to the Joint Advisory Committee on Athletic Injuries of the Ohio High School Athletic Association and the Ohio State Medical Association for study:

"1. Practice should start August 1. Restrictions on equipment would be enforced with only shoes, helmets, and football permitted.

"2. Keeping in mind the necessity of full conditioning, no physical contact drills or scrimmages would be permissible until the third Friday of August.

"3. Practice time would be limited to ninety minutes a day per athlete. This would be in force from the first day of practice until physical contact was permitted.

"4. The above requests if carried out would do much to:

a. Eliminate early contact before proper conditioning has reasonably alleviated the great dangers of physical injuries.

b. Help reduce related ailments such as heat exhaustion and blisters.

c. These ideas would also permit the coach to have ample time to instruct his players in fundamentals and not force him to rush into his program without fully teaching the fundamentals. (A prime source of injuries is a failure to execute the fundamentals with confidence and timing.)

d. It is to be noted that programs of this nature have been instrumental in other states in curtailing injuries.

e. In applying these suggestions, the individual coaches would find them beneficial in that the temptation to violate the rules by conducting early unauthorized practices would be greatly reduced."

There being no further business, the meeting was adjourned.

Attest: HART F. PAGE,
Executive Secretary

Medical College of Ohio at Toledo...

Progress Reported on Plans and Facilities for Ohio's New Medical School: Pilot Group of Students Anticipated by September, 1969

A PROGRESS REPORT on Ohio's newest medical college, the Medical College of Ohio at Toledo, shows program planning well advanced, a number of faculty members named, and a time table set for the building program. Officials anticipate at least a pilot study group of students to begin work by September, 1969, and classes of 100 students to be using facilities possibly by 1971.

To bring its readers up to date on progress of the new school, *The Journal* staff has been in contact with the President of the College, Dr. Glidden L. Brooks. The following article is based primarily on current information and background material furnished through Dr. Brooks' office.

New College Established

First known as the Toledo State College of Medicine, the institution was established by an act of the Ohio General Assembly passed in 1964 and signed by the Governor in December of that year. The name of the College was changed by the General Assembly in 1967 to Medical College of Ohio at Toledo. Initial funds came from a bond issue passed by Ohio voters in May, 1965, plus federal appropriations.

The Governor appointed a nine-member Board of Trustees. Following are current members of the Board:

Bernard R. Baker, Perrysburg, attorney; seven years.

Paul Block, Jr., publisher of *The Blade,* Toledo newspaper; eight years.

James Slater Gibson, attorney and legal adviser to the Toledo Board of Education, was reappointed to the Board for a period of nine years, term ending May 1, 1976.

W. W. Knight, Jr., investment company executive, and chairman of the Toledo-Lucas County Port Authority, six years.

Sister Mary Lawrence, president of Mary Manse College, was reappointed to the Board for a period of nine years, term ending May 1, 1975.

Dr. Frank F. A. Rawling, Toledo physician and president of the Toledo Area Medical College and Education Foundation, five years.

Dr. Byron G. Shaffer, Ottawa Hills, surgeon, four years.

John A. Skipton, Findlay, head of the public affairs department of the Marathon Oil Company, was reappointed to the Board for a period of nine years, term ending May 1, 1974.

Mr. John E. Martin, Toledo, Chairman of the Board of Directors of the Dana Corporation, was appointed to the Board of Trustees of the College for the unexpired term beginning June 29, 1967, and ending May 1, 1973.

Following an extensive search, the Board appointed Dr. Brooks as President, effective July 1, 1966.

Land and Buildings

Prior to appointment of the President, a determination was made as to the most appropriate location for the College; and negotiations were completed with the State Department of Mental Hygiene and Correction for acquisition of a plot of state-owned land in southeast Toledo. This 360-acre site had been utilized for farming by the Toledo State Hospital. In recent years, the site has been surrounded by middle-income housing development. Situated as it is in the growth area of Toledo, officials feel that the site presents an ideal location for the service as well as the educational and research activities of a teaching-medical center.

Currently, intensive site planning is going forward, the local team working closely with the State Architect's Office, and involving the participation of Lester Gorsline Associates International, architectural-engineering consultants specializing in medical school planning. The architectural firm of Minoru Yamasaki and Associates has been selected for master planning. The projected timetable for construction of the first teaching and laboratory unit to accommodate anticipated classes of approximately one hundred students calls for occupancy by 1971, at the earliest.

Program planning has been advanced to the point where a determination has been possible to admit a pilot group of approximately 20 students by September, 1969. Local authorities in Lucas County have made available, essentially without cost, facilities on hospital grounds adjacent to the site selected for permanent development of the medical college. These are permanent and functional facilities in a portion of the building occupied by the William Roche Me-

morial Hospital. Architectural plans for necessary remodeling of this facility are well advanced.

Current Activities

It is the intention that the medical college be closely integrated with the Northwestern Ohio community, Dr. Brooks said. The faculty and staff of the College will participate actively in health-related programs in Northwestern Ohio.

The President and other staff members have participated in the development of a projected Regional Medical Program and the College has been designated operating grantee agent for this program.

A series of close working arrangements is being developed by the medical school and the graduate schools at Bowling Green State University and the University of Toledo. These relationships include joint faculty appointments and the anticipation of doctoral candidates in the graduate schools pursuing research and teaching activities in the medical college facilities. The opportunity for a medical school to serve and be served by two universities is unique and presents a variety of possibilities for future joint programs, Dr. Brooks reported.

Financial Support

The General Assembly of the State of Ohio has provided realistically generous appropriations for development of the school, both capital and operating. The College has enjoyed the highest level of cooperation and support from the Ohio Board of Regents, State Department of Mental Hygiene and Correction, State Department of Public Works, State Department of Finance, State Auditor's Office, the Academy of Medicine of Toledo and Lucas County, the Toledo Planning Commission, and the Lucas County Commissioners.

Staffing and Faculty

The President of the College, since he took office in July of 1966, has been developing organization, recruiting a faculty, and attending to administrative affairs. The administrative duties are shared by Miss Annabelle Isaacs, former office manager at Bowling Green State University, as administrative assistant; Mr. R. Milton Blunk, former business manager for the Toledo Public School system, as assistant to the President; and Mr. Wayne Henry, currently director of the Roger Williams General Hospital in Providence, Rhode Island, as vice-president for administration.

Recruitment of full-time faculty is being timed to make possible the implementation of the projected opening of the College in 1969. As of the end of 1967, department chairmen in physiology, anatomy, and psychiatry have been appointed in addition to the librarian. A number of additional appointments in both the basic and clinical sciences is anticipated over the next six months. Those faculty members currently in residence have been occupied largely by the transfer of their research activities, planning, recruitment for their departments, and development of a curricular structure.

In addition to the full-time faculty, it is contemplated that extensive use will be made of the talents of the medical community and of the local hospitals.

Curricula Vitae of Faculty

Following are names of those holding appointments as of mid-January with brief summaries of the professional backgrounds of each.

* * *

David W. Bishop, Ph. D., will join the faculty on July 1, 1968, as professor of physiology. Born in Philadelphia, Pa., he obtained his Ph. D. degree from the University of Pennsylvania.

Dr. Bishop was formerly a member of the staff of Carnegie Institute of Washington; is presently a visiting lecturer, Cornell University, Ithaca, New York.

* * *

Glidden L. Brooks, M. D., was appointed President of the College, effective July 1, 1966. He has been working at the task of developing the new medical school since that time.

Before accepting the present assignment, Dr. Brooks was director of the Institute for Health Services at Brown University, Providence, R. I., and was associate vice-president for biomedical development. He is a native of Pawnee City, Nebraska, and received his medical degree from Harvard Medical School in 1937. Following several years of training at Children's Hospital, Boston, he was certified as a diplomate of the American Board of Pediatrics. Among appointments, he was director of pediatrics and later executive director at the Central Maine General Hospital, Lewiston; was on the staff of Children's Hospital, Philadelphia, and on the faculty of the University of Pennsylvania. At the University of Pittsburgh he was professor of hospital administration, and coordinator of hospitals and clinics. His professional background in administrative medicine includes public health work.

* * *

Edward J. Cafruny, M. D., Ph. D., will join the faculty July 1, 1968, as professor and chairman of the Department of Pharmacology and Experimental Therapeutics. Born in New Castle, Pa., he obtained a Ph. D. degree from Syracuse University, and an M. D. degree from the University of Michigan Medical School. Dr. Cafruny was formerly associate professor of pharmacology at the University of Minnesota, Minneapolis.

* * *

Liberato J. A. DiDio, M. D., Ph. D., accepted appointment as professor and chairman of the Department of Anatomy, effective April 1, 1967. Dr. DiDio was born in Sao Paulo, Brazil, and immigrated to the

United States in 1963. He received the M. D. and a Ph. D. degree from the Faculty of Medicine, University of Sao Paulo. He was professor of anatomy at Northwestern University Medical School, Chicago, prior to accepting the appointment in Ohio.

* * *

William M. Easson, M. D., accepted appointment as professor and chairman of the Department of Psychiatry as of July 1, 1967. Dr. Easson was born in Evanston, Illinois, and educated in Scotland. He attended the University of Aberdeen, where he obtained the M. D., M. B., and Ch. B. degrees. He was a member of the faculty of the Menninger School of Psychiatry prior to accepting the present appointment.

* * *

Leonard Nelson, Ph. D., was named professor and chairman of the Department of Physiology effective January 1, 1968. Born in Philadelphia, Pa., his Ph. D. degree was obtained from the University of Minnesota. Dr. Nelson was associate professor of physiology at Emory University, Atlanta, Ga., prior to accepting the position of program director of the Developmental Biology Program, Cellular Biology Section, Division of Biological and Medical Sciences, National Science Foundation, Washington, D. C.

* * *

Homer E. Stavely, Ph. D., on November 1, 1967, became research coordinator and research professor of biochemistry. Dr. Stavely was born in Junction City, Kansas. He obtained his Ph. D. degree from Iowa State University of Science and Technology, and an Honorary D. Sc. degree from the University of Redlands, Redlands, California. He was formerly employed at Mead Johnson and Company, Evansville, Ind., as director of biological chemistry and assistant to the vice-president of the company. For a temporary period, he is acting director of the Institute for Medical Research at the Toledo Hospital.

* * *

C. Robert Tittle, M. D., was named clinical professor of medicine on the faculty of the Medical College on July 1, 1967. Dr. Tittle was born in Philadelphia, Pa. He obtained his M. D. degree from the University of Pennsylvania, Philadelphia. He is also a member of the staff of Maumee Valley Hospital, Toledo. At the present time Dr. Tittle is director of the Northwestern Ohio Regional Medical Program, with offices in Toledo.

* * *

Ronald M. Watterson, named librarian of the Medical College on September 1, 1967, was born in Butler, Pa., and received his Master of Library Science from Rutgers — the State University, New Brunswick, New Jersey. He is currently engaged in graduate work at the University of Pittsburgh. He was formerly the deputy director of Welch Medical Library, Johns Hopkins University, Baltimore, Md.

* * *

Earl H. Freimer, M. D., was appointed professor of microbiology and medicine and chairman of the Department of Microbiology, effective July 1, 1968. Dr. Freimer was born in New York City. He obtained his M. D., degree from the State University of New York, Upstate Medical Center, Syracuse, New York. He is presently an assistant professor, the Rockefeller University, and associate physician, the Hospital of The Rockefeller Institute, New York, New York.

* * *

Edward L. Burns, M. D., was appointed clinical professor of pathology. Dr. Burns was born in Kansas City, Missouri. He obtained his M. D. degree from Washington University, St. Louis, Missouri. Doctor Burns is president, Board of Trustees of the Cancer Cytology Research Fund of Toledo, Inc., Toledo.

* * *

Howard S. Madigan, M. D., was appointed associate clinical professor of surgery. Dr. Madigan was born in Washington, D. C. He received his M. D. degree from Georgetown University School of Medicine, Washington, D. C. Dr. Madigan is director of medical education, St. Vincent Hospital and Medical Center, Toledo.

* * *

James Scala, Ph. D., was appointed Lecturer in Anatomy. Dr. Scala was born in Ramsey, New Jersey. He received his Ph. D. degree from Cornell University, Ithaca, New York. Doctor Scala is section chief, Life Sciences Section, Department of Fundamental Research, Owens-Illinois, Inc., Toledo.

What To Write For

Alcohol and Alcoholism — This U. S. Public Health Service Publication No. 1640 pertains to work of the National Center for Prevention and Control of Alcoholism, established in 1966 within the National Institute of Mental Health. The publication reviews present knowledge of alcohol; the nature and extent of drinking problems; the identification, treatment, and prevention of alcoholism; and the status of current research. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price 50 cents.

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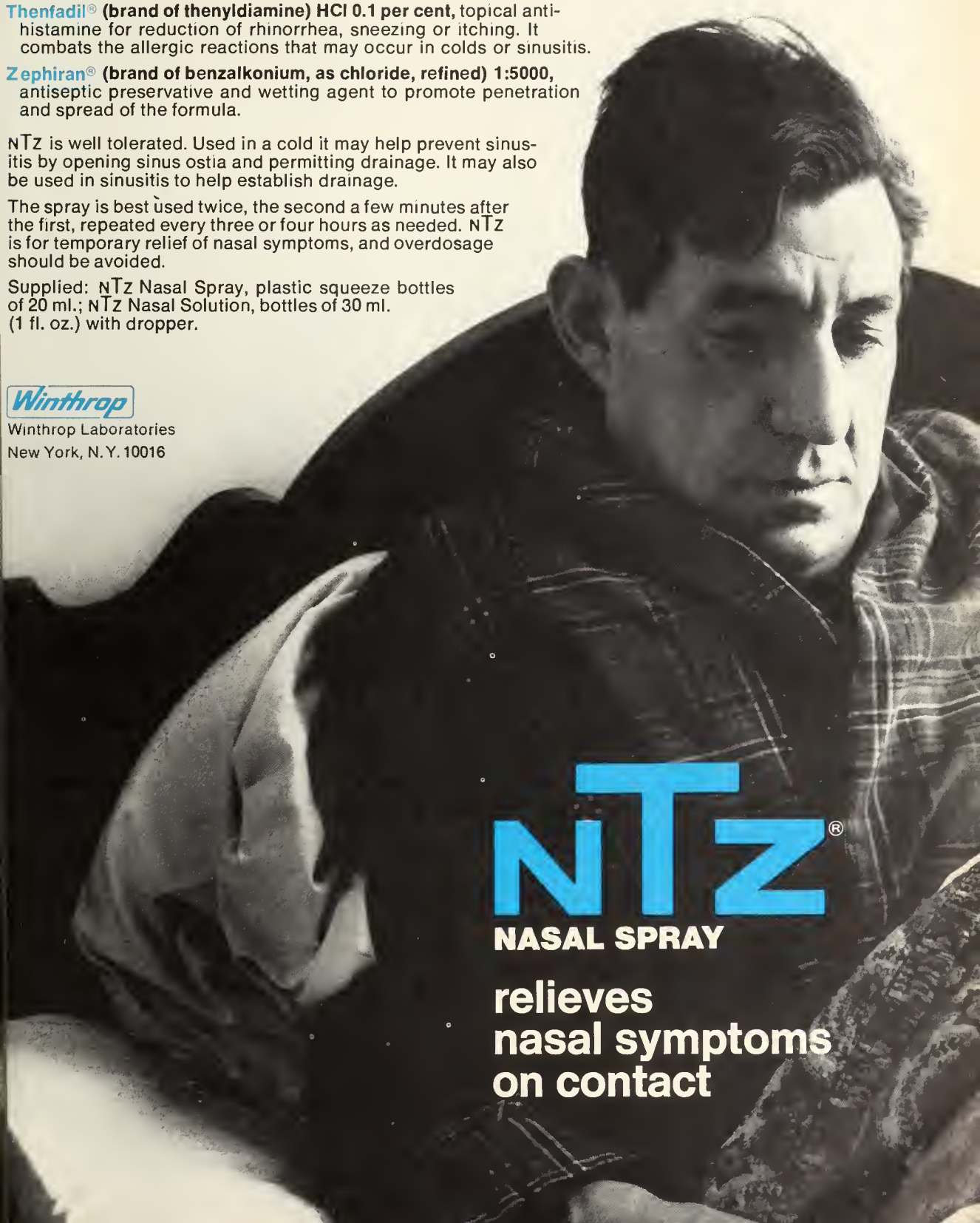
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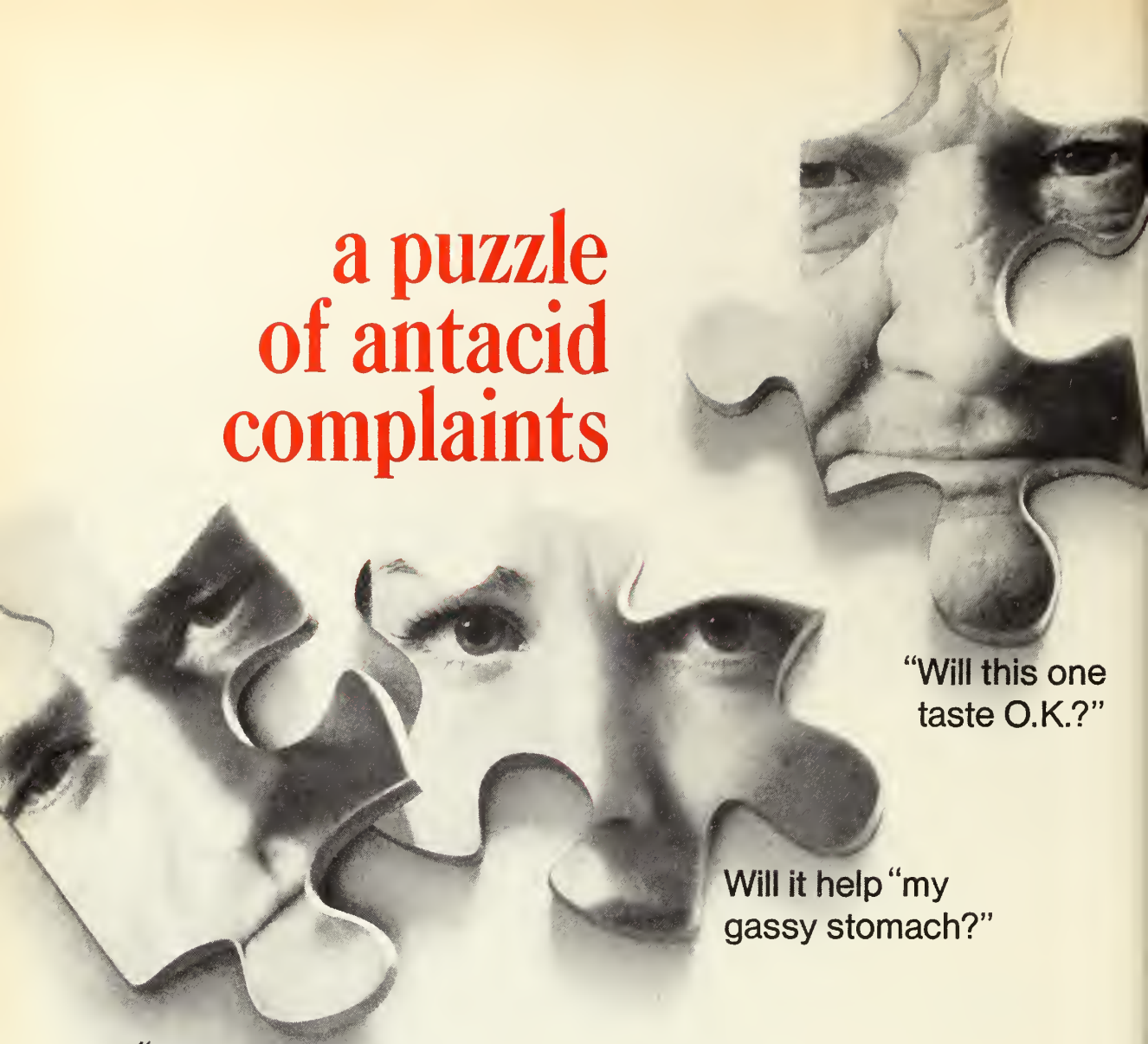
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Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart

Division/Pasadena, Calif.
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Twins ..... $17.00-$25.00

TERRACE HILTON HOTEL
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(Woman's Auxiliary Headquarters)

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Doubles (none available)
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Singles $12.00
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Make Your HOTEL RESERVATIONS

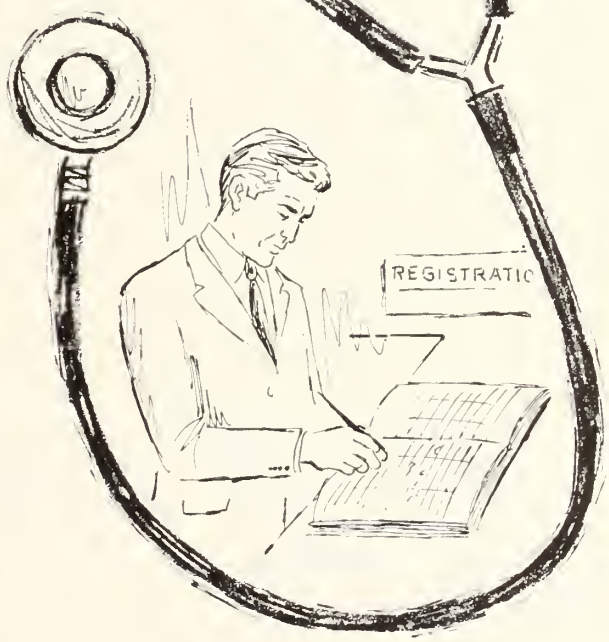
FOR THE

1968 OSMA ANNUAL MEETING

Cincinnati May 13-17

All rotes subject
to change

If you plon ta share a room,
pleose indicate name af
roommote.



HOTEL RESERVATION BLANK
(Mail to Hotel of Choice)

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(Nome of Hotel)

_____Cincinnati, Ohio
(Address)

Please reserve the follawing accommodations during the periad of the Ohia State Medical Associatian Annual Meeting, May 13-17 (ar far periad indicated)

_____ Single Room

_____ Double Room

_____ Twin Room

Other accammadations_____

Price Range_____

Arriving May_____ at _____A.M. _____P.M.

PLEASE VERIFY MY RESERVATION

NAME_____

ADDRESS_____

_____

The PHYSICIAN and - -

1968 OSMA Annual Meeting — May 13 - 17 . . .

THIS YEAR'S GENERAL THEME for the 1968 OSMA Annual Meeting, "The Physician and His Community," opens many avenues for a week of educational and informative sessions for those attending. The physician is becoming more and more involved with HIS Community and we are certain he will find the programs of great interest and value in his wide scope of serving His Community and patients as a well-informed physician.

Listed below are the General Sessions which will be held at the Cincinnati-Exposition Center and participants as of this printing.

TUESDAY, MAY 14

1:00 P. M. (Room 209)

"Medical Hooey"

Program sponsored by OSMA Committee on Environmental Health and Public Health.

Speakers: William H. Gordon, M. D., Lubbock, Texas, Oliver Field, Dept. of Investigation, American Medical Association.

3:00 P. M. (Room 209)

"Preventive Legal Medicine"

Participants: Mr. Frank E. Kunkel, Executive Secretary, State Board of Pharmacy, Columbus.

W. T. Washam, M. D., Executive Secretary, State Medical Board, Columbus.

Carl Wasmuth, M. D., Cleveland.

WEDNESDAY, MAY 15

9:00 A. M. (Room 209)

Tenth Annual Ohio Cancer Conference

Participants: Joseph A. Bonta, M. D., President, American Cancer Society, Ohio Division, Inc., Columbus.

William F. Boukalik, M. D., Vice-President, American Cancer Society, Ohio Division, Inc., Cleveland.

E. Cuyler Hammond, Sc. D., Vice-President for Epidemiology and Statistics, The American Cancer Society, Inc., New York.

Robert E. Howard, M. D., President, The Ohio State Medical Association, Cincinnati.

Arthur G. James, M. D., Clinical Professor of Surgery, The Ohio State University; Member, Board of Directors, The American Cancer Society, Inc., Columbus.

John Peter Minton, M. D., Administrative Chief Resident in Surgery, The Ohio State University, Columbus.

Albert B. Sabin, M. D., The Children's Hospital Research Foundation, Cincinnati.

Subjects: "Present Status of the Search for a Possible Role of Viruses in Human Cancer" — Dr. Sabin.

"Cancer Immunology" — Dr. Minton.

"Cancer Prevention" — Dr. Hammond.



- His COMMUNITY

Netherland Hilton Hotel — Cincinnati-Exposition Center

WEDNESDAY (Contd.)

11:00 A. M. (Room 209)

"The Management of Head and Neck Cancer"

Program sponsored by OSMA Section on Plastic Surgery.

Participants: John C. Gaisford, M. D., Pittsburgh, Pennsylvania

Shattuck W. Hartwell, Jr., M. D., Cleveland.

F. Stanley Hoffmeister, M. D., Albany, N. Y.

1:30 P. M. (Room 209)

"Medicare Plus Two Years — How Is the Medical Profession Faring?"

Speaker: Edward R. Annis, M. D., Past President, American Medical Association.

3:00 P. M. (Room 209)

"Government Medical Care Programs And OSMA Policies"

Program sponsored by the OSMA Committee on Government Medical Care Programs.

Panel Program

Moderator: H. William Porterfield, M. D., Columbus, Chairman, Committee on Government Medical Care Programs.

Participants: Dwight L. Becker, M. D., Lima, Chairman, Subcommittee on Comprehensive Health Planning.

Chester H. Allen, M. D., Lima, Chairman, Subcommittee on Heart Disease, Cancer, and Stroke.

WEDNESDAY (Contd.)

Carl Madsen, Jr., M. D., Painesville, Chairman, Subcommittee on Title 18.

Paul Jones, M. D., Zanesville, Chairman, Subcommittee on Title 19.

William Dorner, Jr., M. D., Akron, Member, Subcommittee on Title 18.

Robert E. Tschantz, M. D., Canton, Subcommittee on Appalachia.

THURSDAY, MAY 16

9:00 A. M. (Room 209)

"Enhancement of Physical Fitness of the Cardiac, Resolving Controversy"

Program sponsored by the Ohio State Heart Association.

Participants: Sanford R. Courter, M. D., Cincinnati, President, Ohio State Heart Association.

Herman R. Hellerstein, M. D., Cleveland, Associate Professor of Medicine, Case Western Reserve University School of Medicine.

Robert E. Howard, M. D., Cincinnati, President, Ohio State Medical Association.

J. Lester Kobacker, M. D., Toledo, Member, Executive Committee, Ohio State Heart Association.

11:00 A. M. (Room 211)

"The Treatment of Chronic Renal Failure"

Speaker: Victor Vertes, M. D., Cleveland, Director, Division of Medicine, Mt. Sinai Hospital.

(Continued on Next Page)



OSMA Annual Meeting

THURSDAY (Contd.)

1:30 P. M. (Room 309)

"Emergency Room Problems"

Program sponsored by Ohio Committee on Trauma, American College of Surgeons.

Panel Program

Moderator: Nicholas J. Giannestras, M. D., Cincinnati.

Participants: Joseph M. Strong, M. D., Elyria.

Mr. Curt N. Daramour, Medical Technical Services, Inc., Fairview Park.

Mrs. Mary Garrity, R. N., Columbus, Mt. Carmel Hospital.

W. Thomas Washam, M. D., Columbus, Executive Secretary, State Medical Board.

Robert Vogel, M. D., Dayton, Health Commissioner of Montgomery County.

Mr. John C. Glandon, C. P. C. U., Columbus, Insurance Specialist.

Richard C. Brandes, M. D., Columbus.

FRIDAY, MAY 17

9:00 A. M. (Room 209)

"The Pill"

Program sponsored by the OSMA Committee on Medicine and Religion.

Panel Program

Moderator: Rev. Dr. Paul B. McCleave, Director, Dept. of Medicine and Religion, AMA, Chicago, Illinois.

Participants: Frank J. Ayd, Jr., M. D., Baltimore, Maryland.

Helen I. Glueck, M. D., Cincinnati, Cincinnati General Hospital.

Rabbi Robert L. Katz, Cincinnati, Professor of Human Relations, Hebrew University College.

The Rev. L. H. Mayfield, Cincinnati, Chaplain, Christ Hospital.

The Rev. Father Donald McCarthy, Cincinnati, Associate Professor of Philosophy, Mt. St. Marys Seminary.

Edward T. Tyler, M. D., Los Angeles, California, Clinical Professor of Medicine & Obstetrics & Gynecology, UCLA School of Medicine.

11:00 A. M. (Room 209)

"Management Problems In Juvenile Diabetes"

Program sponsored by the University of Cincinnati College of Medicine.

Provisions in the OSMA Bylaws Pertaining to Nomination Of President-Elect

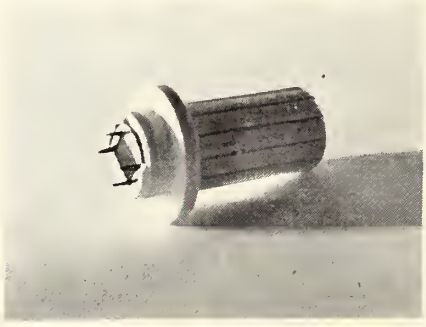
Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cincinnati, May 13-17.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 18.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 1 (a), entitled "Nomination of President-Elect."

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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APPLICATION FOR SPACE

SCIENTIFIC AND HEALTH EDUCATION EXHIBITS
1968 ANNUAL MEETING, OHIO STATE MEDICAL ASSOCIATION
Cincinnati-Exposition Center, Cincinnati, Ohio, May 13 - 17

Title of Exhibit: .....

Name(s) of Exhibitor(s): .....

.....

Institution (if desired): .....

City .....

Do you have a built-in exhibit? .....

Description of Exhibit: (Attach 200 word description to this blank for use in Annual Meeting Program)

Exhibit will consist of the following: (Check which)

Charts and posters ..... Photographs ..... Drawings ..... X-rays .....

Specimens ..... Moulages ..... Other material .....
(Describe)

Booth Requirements:

Amount of wall space needed? .....

Back wall ..... Side walls .....

Square feet needed? .....

Shelf desired? (yes or no) .....

Transparency Cases:

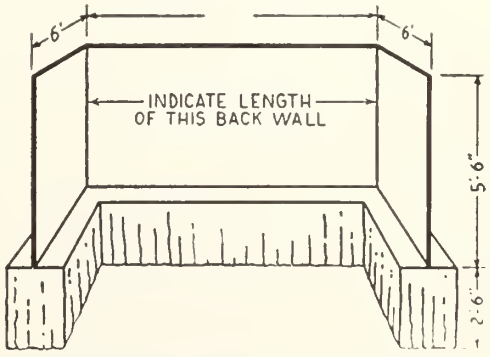
Needed? (yes or no) .....

If answer "yes," give following information:

Number of transparencies to be shown and size of each .....

.....

.....



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

ate .....

.....
Signature of Applicant

.....
Mailing Address, Street

.....
City, State, Zip Code

ENd APPLICATION TO: COMMITTEE ON SCIENTIFIC WORK, OHIO STATE MEDICAL ASSOCIATION,
17 SOUTH HIGH STREET, SUITE 500, COLUMBUS, OHIO 43215
DEADLINE FOR FILING APPICATIONS EXTENDED TO FEBRUARY 15

GASLIGHT PARTY

Netherland Hilton Hotel
(Pavilion Caprice Room)

Wednesday, May 15, 1968
7:00 P.M. until ? ? ?

GAY 90 YEARS



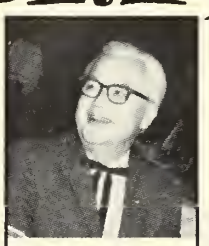
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THE ANNUAL OMPAC LUNCHEON

THURSDAY, MAY 16
Room 210
Cincinnati-Exposition Center



Congressman Taft

Speaker . . . . The Honorable
ROBERT TAFT, JR.
FIRST OHIO DISTRICT

11:30 A. M.	Cash Bar
12:00 Noon	Luncheon
12:45 P. M.	"Lets Take a Look at the Record!"
	Progress Report — Frank H. Mayfield, M. D., Chairman, OMPAC Board
1:00 P. M.	After Luncheon Speaker — Hon. Robert Taft, Jr.

Tickets . . . $5.00 per person

GASLIGHT PARTY

Complete and Forward to:
THE OHIO STATE MEDICAL ASSOCIATION
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Columbus, Ohio 43215

OMPAC LUNCHEON

Enclosed is $_____ to pay for:

_____Tickets to Gaslight Party ($8.00 per person)

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Wednesday, May 15
Netherland Hilton Hotel
7:00 P.M.
Featuring Chicago's
GASLIGHT ROADSHOW

Thursday, May 16
Cincinnati-Expositian Center
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Fun!
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Watch for These Technical Exhibitors

And Their Special Features at the OSMA Annual Meeting, New Cincinnati-Exposition Center, May 13 - 17

PLANNERS OF THE PROGRAM are proud to report that 90 reservations for booth space have been confirmed for the 1968 OSMA Annual Meeting, May 13 - 17, at the new Cincinnati-Exposition Center, Cincinnati. All of those who attend are urged to take advantage of this opportunity to view the exhibits and talk to experts representing the various companies. At no time is a physician in better position to visit, and ask questions of the various representatives in a consolidated area. These are the companies physicians have learned to trust through years of association.

For the convenience of those attending, most of the programs are coordinated to break at a given time in the morning, and again in the afternoon. This arrangement affords time to view exhibits without missing favorite scientific sessions. Visits with the exhibitors assure them that Ohio physicians appreciate their selection of the OSMA Annual Meeting for presenting their products and services.

For convenience in checking locations, the exhibitors are arranged according to booth numbers. Exhibits will open for viewing at NOON on Tuesday, May 14, and will close at 1:00 P. M. on Friday, May 17. Actual exhibit hours are as follows:

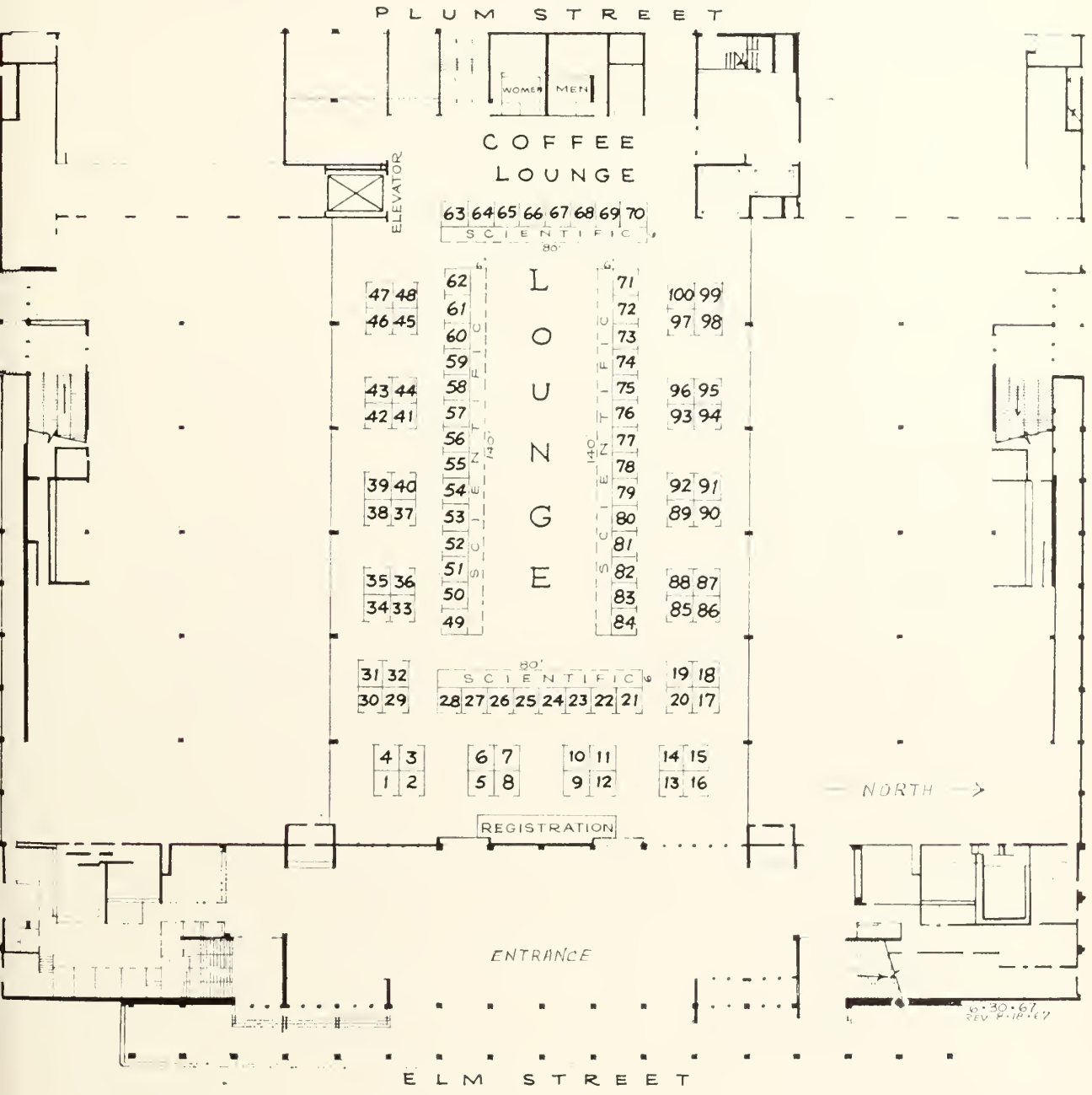
Tuesday, May 14	12:00 Noon to 4:30 P. M.
Wednesday, May 15	9:00 A. M. - 4:00 P. M.
Thursday, May 16	9:00 A. M. - 4:00 P. M.
Friday, May 17	9:00 A. M. - 1:00 P. M.

Booth No.	Company and City
1-2	Crocker-Fels Company, Cincinnati
3	3M Business Products, Cincinnati
4	Flint Laboratories Division of Travenol Laboratories, Inc., Morton Grove, Ill.
5	Burroughs Wellcome & Co. (USA) Inc., Tuckahoe, N. Y.
6	New York Life Insurance Co., Columbus and Cincinnati
7	Parke, Davis & Company, Detroit, Mich.
8	Eli Lilly and Company, Indianapolis, Ind.
9	W. B. Saunders Company, Philadelphia
10	Merck Sharp & Dohme, West Point, Pa.
11	Pfizer Laboratories, New York
12	Lederle Laboratories, Pearl River, N. Y.
13	E. R. Squibb & Sons, New York
14	Imperial Fashions, Div. of British House, Los Angeles, Calif.
15	Organon, Inc., West Orange, N. J.
16	G. D. Searle & Co., Chicago
17	J. B. Lippincott Company, Philadelphia
18	Cincinnati & Suburban Bell Telephone Company, Cincinnati
19	USV Pharmaceutical Corp., New York
20	Schering Corporation, Union, N. J.
21-22	Hoechst Pharmaceutical Co., Div. of American Hoechst Corp., Cincinnati
23	Turner and Shepard, Inc., Columbus
24-25	The Procter & Gamble Co., Cincinnati
26-27	The Max Wocher & Son Co., Cincinnati
28	Sandoz Pharmaceuticals, Hanover, N. J.
29	Mead Johnson Laboratories, Evansville, Indiana
30	S. H. Camp & Company, Jackson, Mich.
31	Nationwide Insurance, Columbus
32	Geigy Pharmaceuticals, Ardsley, N. Y.
33	The Wm. S. Merrell Company, Cincinnati
34	Pepsi Cola Bottling Company, Cincinnati
36	Clayton L. Scroggins Associates, Cincinnati
37	Philips Roxane Laboratories, Columbus

(Continued on Page 246)

Cincinnati—Exposition Center

A Key to Roster of Technical Exhibits on Accompanying Pages Sketch Shows Location of Exhibit Booths by Numbers



Morning, Noon, and Afternoon Breaks in the Program Will Give Ample Time for Frequent Visits to the Exhibit Floor

Technical Exhibitors (Cont'd.)

Booth No.	Company and City
40	7-Up Bottling Co., Cincinnati
41	Wm. P. Poythress & Co., Inc., Richmond, Virginia
42	North American Pharmacal Co., Dearborn, Mich.
43	Massachusetts Indemnity & Life Insurance Co., Cincinnati
44	Key Pharmaceuticals, Inc., Miami, Florida
45	Medco Products Co., Inc., Tulsa, Okla.
46	H. P. Gardner Co., Columbus
47	Ross Laboratories, Columbus
48	Marshall Erdman & Associates, Madison, Wisconsin
49	Smith Kline & French Laboratories, Philadelphia
50	Carnation Company, Los Angeles
51	PRO Services, Inc., Philadelphia
52	Hewlett-Packard Co., Skokie, Illinois
53	Breon Laboratories, Inc., New York
54	Janrus Recorders Corp., New York
55	Professional Administrative Service, Cincinnati
56	General Electric Company X-Ray Dept., Indianapolis, Ind.
57	Professional Office Buildings, Inc., Madison, Wisconsin
58	International Business Machines, Cincinnati
59	Ohio Medical Indemnity Inc., Columbus
60	National Institute for Better Reading, Inc., Bellmore, N. Y.
61	Tice & Co. Inc., Columbus
62	Warren-Teed Pharmaceuticals Inc., Columbus
63	Ciba Pharmaceutical Company, Summit, New Jersey
64	Endo Laboratories Inc., Garden City, New York
65	The Medical Protective Company, Fort Wayne, Ind.
66	Barry Laboratories Inc., Detroit, Mich.
67	Wm. A. Rudd, Inc., Cincinnati
68	Ayerst Laboratories, New York
69	Ortho Pharmaceutical Corp., Raritan, New Jersey
70	Audio Digest Foundation, Los Angeles
71	Winthrop Laboratories, New York
72-73	Contour Chairs of Columbus, Inc., Columbus
74	William H. Rorer, Inc., Ft. Washington, Pennsylvania
75	Scudder, Stevens & Clark, Cincinnati
76	Physicians Planning Corporation, Cincinnati
77	Roche Laboratories, Nutley, N. J.
78	Medical-Dental-Hospital Bureau of Cincinnati, Cincinnati
79	Loma Linda Foods, Riverside, California
80	The Dow Chemical Company, Midland, Michigan
81	Astra Pharmaceutical Products, Inc., Worcester, Mass.
82	Beecham Research Laboratories, New York
83	Arnar-Stone Laboratories, Inc., Mt. Prospect, Illinois
84	Gerber Products Company, Fremont, Michigan
85	Abbott Laboratories, North Chicago, Ill.
86	Medical Economics Consultants, Inc., Dayton
88	Siemens Medical of America Inc., Addison, Illinois
89	The Coca-Cola Company, Atlanta, Ga.
92	Stiefel, Oak Hill, New York
93	Daniels-Head & Associates, Inc., Portsmouth
96	Royal Crown Bottling Co., Cincinnati
97	Wallace Pharmaceuticals, Cranbury, New Jersey
100	Robert L. Rupp & Associates, Columbus

ACCREDITATION NOTES . . .



A Question-and-Answer Column Conducted in Collaboration with

The Joint Commission on Accreditation of Hospitals

John D. Porterfield III, M. D., Director

Q. Are there any definite standards which an emergency room must meet before the hospital is accredited by JCAH?

A. Yes. presently these are minimal and brief, and can be repeated here:

"a) There shall be a written plan for the care of mass casualties. This plan should be coordinated with the inpatient and outpatient services of the hospital and rehearsed by key personnel at least twice a year.

"b) If an emergency service is maintained:

"1) The department shall be well organized, directed by qualified personnel, and integrated with other departments of the hospital.

"2) Facilities shall be provided to assure prompt diagnosis and emergency treatment. There shall be adequate medical and nursing personnel available at all times.

"3) Adequate medical records on every patient must be kept."

In addition, the Board of Commissioners has expressed the explicit policy that patients shall be seen promptly, within a time pertinent to the condition of the patient.

However, hospital emergency services have become so much more important a feature of the modern hospital that standards covering these services are among the first being reviewed and rewritten by the Board. It is expected that the new language will be adopted and publicized in the near future. In essence, it is expected they will call for every general hospital to have an emergency plan and minimal emergency services and to join in a community-wide agreement on which hospitals will provide more comprehensive emergency services. Finally, they will outline the higher standards to be met when a fully integrated emergency department is provided.

Q. Does the JCAH mainly concern itself with physical facilities of a hospital or does it also evaluate such items as availability of nurses, teaching programs, intern programs for education, etc.?

A. The JCAH is concerned with the quality of care provided the patient. It recognizes that quality of care is in great part both an intangible and a judgmental value. It recognizes that the direct measurement of quality is at best debatable. It attempts, therefore, to measure a number of factors which affect quality of care. If these measurements meet standards, the potential for quality is enhanced or quality itself is documented. If they do not, the potential for quality is handicapped.

The factors evaluated include the physical plant and its safe and sanitary maintenance; the organization of the hospital, its governing body and its medical staff; the presence of adequate and efficient resources for diagnosis, treatment, and general care (including sufficient numbers of qualified nursing personnel); evidence of the attentive performance of the functions of the governing body, the administration, and the organized medical staff, as shown by records, minutes, and discussion; evidence of effective working relations among these elements of a hospital; and evidence of individual patient care as shown by complete, pertinent, up-to-date clinical charts.

While a dynamic program of continuing medical education for the professional staff is considered one of the most essential elements for quality of care, intern and resident training programs are within the jurisdiction of The Council on Medical Education of the AMA and the specialty boards.

Questions from *The Journal*'s readers may be directed to the Joint Commission on Accreditation of Hospitals, John D. Porterfield III, M. D., Director, 645 N. Michigan Avenue, Chicago, Illinois 60611, or to *The Journal* for referral to Dr. Porterfield and his staff.





Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, Equanil® often may play an important role in medical and surgical aftercare.

tions: For use in management of anxiety and tension occurring or as accompanying symptom complex to medical and surgical ers and procedures. Though not a hypnotic, fosters normal rough antianxiety and related muscle-relaxant properties.

raindications: History of sensitivity to meprobamate.

ortant Precautions: Carefully supervise dose and amounts scribed, especially for patients prone to overdose themselves. cessive prolonged use has been reported to result in dependence habituation in susceptible persons, as alcoholics, ex-addicts, nd other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe with- drawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or danger- ous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meproba- mate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythema- tous maculopapular rash, generalized or confined to groin. Acute nonthrombo- cytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphy- laxis, stomatitis and proctitis (1 case) and hyperthermia. Treat sympto- matically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulo- cytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (in- somnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REOIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Wyeth® SERVICE TO MEDICINE

Equanil®

(meprobamate)

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Professionally posed.

Revisions in the Social Security Tax Structure for 1968

THE Social Security Amendments of 1967, passed by Congress late in December and signed by the President in early January, bring about changes in tax structure of considerable interest to physicians, especially in regard to self-employment taxes and withholdings from employees' wages.

Beginning January 1, 1968, the base on which self-employed persons must pay social security taxes is the first $7,800 of earnings — up from the previous $6,600. The total rate of deduction remains the same for 1968 as it was under the old law — 6.4 per cent. This percentage is the sum of 5.8 per cent for OASDI (old-age, survivors, and disability insurance) and 0.6 per cent for HI (health insurance). Included in the law are built-in increases in the percentage deductions for years following 1968.

The Social Security tax on self-employment earnings is to be paid quarterly with the Declaration of Estimated Tax (Form 1040ES).

Payroll Withholdings

Beginning January 1 also, the base on which employers are required to deduct social security taxes from employees' wages, and make their own matching contributions, is increased to the first $7,800 of earnings. The employer will deduct 4.4 per cent from the employee's salary up to $7,800, and pay a matching amount himself. This percentage is the sum of 3.8 per cent for OASDI, and 0.6 per cent for health insurance.

The section on "Social Security Taxes" in the tax roundup article, pages 1632-1633, December issue of *The Journal,* contained an editorial note referring to pending legislation in Congress — H. R. 12080. The information pertaining to social security taxes in that article, written before the new law was passed, is applicable to 1967. The information contained on this page should be substituted in dealing with 1968 taxes.

Under the new amendments, a worker under age 72 who is receiving social security benefits may earn up to $1,680 without having any benefits withheld. A worker over age 72 may earn any amount and not lose benefits.

Increased benefits under the new amendments become effective February 1, 1968.

Some Other Changes

Some changes have been made in regard to coverage under the social security program.

The old law provided that people who reach age 65 in 1968 and are not entitled to monthly social security benefits could not get hospital insurance unless they had six calendar quarters of social security work credits. The new law reduces this requirement to three calendar quarters.

For people who reach age 65 after 1968, the amount of work credits needed increases by three quarters each year.

Changes also were made in the provisions for medical insurance enrollment. A person who is not enrolled for medical insurance may enroll during the first three months of any year, provided this period begins within three years after he had his first opportunity to enroll. People already 65 or older who do not have medical insurance may enroll through April 1, 1968. If they do not enroll by that date, they must wait until 1969 for another opportunity to do so.

The premium for medical insurance is presently $3 per month. It is scheduled to be increased to $4 per month in April, 1968, and to remain at this rate until June 30, 1969.

Course in Diagnostic Roentgenology Offered by Cincinnati U

The ninth annual Refresher Course in Diagnostic Roentgenology will be held by the Radiology Department of the University of Cincinnati College of Medicine under the director of Dr. Benjamin Felson from June 3 through June 8. The course will include, in addition to lectures and demonstrations, teaching methods employing audience participation. Saturday, June 8, will be devoted entirely to radiation physics because of the desires of many former participants.

Further information concerning the course, which is open to radiologists and radiology residents, may be obtained by writing to Dr. Harold B. Spitz, Department of Radiology, Cincinnati General Hospital, Cincinnati, Ohio 45229.

Ad Astra

Joseph Andreas Bauer, Sr., M. D., Strongsville; Franz Josef University, Szeged, Hungary, 1925; aged 67; died December 19; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A former practitioner in Yugoslavia, Dr. Bauer practiced for about 20 years in Europe before coming to this country. He set up practice in Strongsville in 1951 after taking residency training in Cleveland. He was associated in practice with his son, Dr. Joseph A. Bauer, Jr. Other survivors are his widow, a daughter, a brother, and a sister.

Charles F. Bowen, M. D., Columbus; Starling Medical College, Columbus, 1903; aged 89; died December 11; member of the Ohio State Medical Association, the American Medical Association, and the Radiological Society of North America. Retired in recent years, Dr. Bowen formerly practiced for many years in Columbus, specializing in radiology. Among professional associations, he was on the staffs of Grant and Mercy hospitals. A veteran of the Spanish-American War, he is survived by a daughter.

Edward Charles Jenkins, M. D., Delaware; Ohio State University College of Medicine, 1938; aged 57; died December 10; member of the Ohio State Medical Association, the American Medical Association, American Fracture Association, International College of Surgeons, and the American Society of Abdominal Surgeons; diplomate of the American Board of Surgery. A practitioner in Delaware for about 20 years, Dr. Jenkins was chief surgeon at the Jane M. Case Hospital in Delaware, and was on the surgical staffs of Union County Memorial Hospital, in Marysville, and the Morrow County Hospital, in Mt. Gilead. A lieutenant commander in the Navy during World War II, he was a member of the American Legion and formerly served as district chairman of the Legion's Americanism Committee. Other affiliations included memberships in several Masonic bodies, the Knights of Pythias, Episcopal Church, and the Kiwanis Club. The Jenkins Foundation was organized by the family in 1961 to help young people toward careers in medicine and allied fields. Survivors include his widow, five daughters, a son, his mother, and step-father.

Arthur Karl Joerling, M. D., Cincinnati; University of Cincinnati College of Medicine, 1927; aged 71; died November 21; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and the American Geriatrics Society. Dr. Joerling's practice of about 40 years in Cincinnati was primarily in the Clifton area. Among survivors are a foster daughter and two brothers.

Robert W. Kropp, M. D., Columbus; Ohio State University College of Medicine, 1926; aged 65; died December 16; member of the Ohio State Medical Association, the American Medical Asso-



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ciation, and the American College of Chest Physicians. A practitioner in Columbus, specializing in chest diseases, Dr. Kropp was also an insurance examiner. He was chairman of the board of Benjamin Franklin Hospital, was active in tuberculosis, and health organization work, and was affiliated with several Masonic bodies. Survivors include his widow, three daughters, and a sister.

Robert Cline Markey, M. D., Worthington and Columbus; Cornell University Medical College, 1931; aged 62; died December 22; member of the Ohio State Medical Association, the American Medical Association, American Academy of Pediatrics, American Geriatrics Society; diplomate of the American Board of Pediatrics. Dr. Markey was chief of the health insurance benefits program for the Ohio Department of Health, a post he assumed in July of 1966, after serving 12 years as health commissioner for Wood County. He previously served a short time with the Ohio Department of Health as a consultant in pediatrics. His early career centered in Dayton where he practiced pediatrics. He was a veteran of World War II, and among affiliations he was a member of the Presbyterian Church and the Kiwanis Club. Survivors include his widow, a daughter, a son, his mother, and a sister.

Frederic George Maurer, Sr., M. D., Lima; St. Louis University School of Medicine, 1920; aged 74; died December 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Maurer was a practitioner of long standing in Lima where he specialized in internal medicine. He began his career at Delphos where he practiced for a few years before taking specialized training. He was a veteran of World War I and was an active member of the Northwestern Ohio Medical Association and a past president of that organization. Other affiliations included membership in the Elks Lodge, the Catholic Church, Holy Name Society, and Knights of Columbus. Dr. Frederic G. Maurer, Jr., also of Lima, is one of three surviving sons.

Edward Truman Sager, M. D., Marion; Cincinnati College of Medicine and Surgery, 1897; aged 101; died December 8; former member of the Ohio State Medical Association and the American Medical Association. In spite of his advanced age, Dr. Sager was still seeing patients within the past few years. A general practitioner over a span of 69 years, he had practiced in Hepburn, Columbus, Magnetic Springs, and Fostoria, before his move to Marion. His wife who died in 1965 also was a physician. Two daughters survive.

Robert Dorwin Spencer, M. D., Piqua; Rush Medical College, 1911; aged 82; died August 12; member of the Ohio State Medical Association, the American Medical Association, and Radiological Society of North America. A native of the Piqua area, Dr. Spencer practiced there for many years before his retirement. His specialty was radiology.

Frederick Conkling Swing, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1904; aged 87; died December 4. A practitioner of long standing in Cincinnati, Dr. Swing was former Hamilton County coroner and a former county commissioner. He was a veteran of World War I, and a member of the American Legion. Other affiliations included membership in the Masonic Lodge and the Kiwanis Club. His widow and a son survive.

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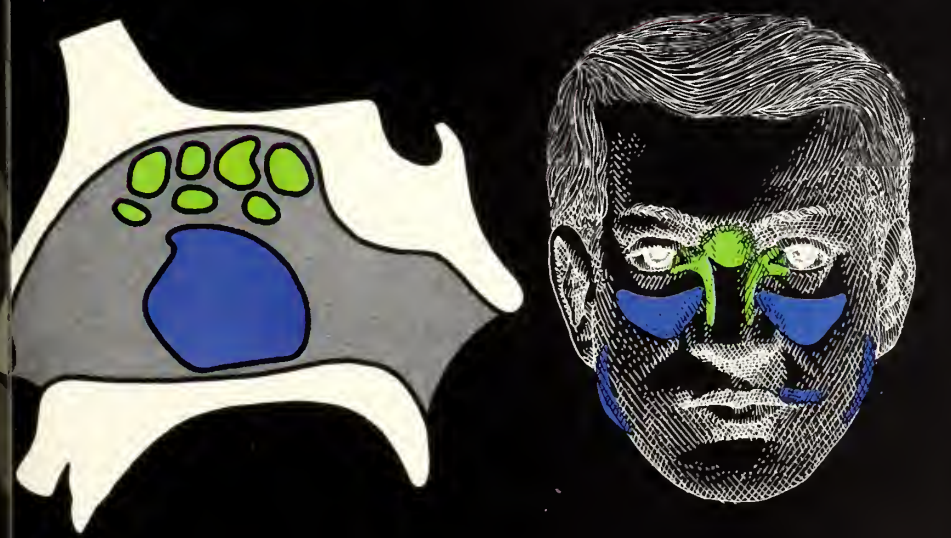
Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

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Activities of County Societies...

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

HAMILTON

Two veteran physicians were honored at the November 21 meeting of the Academy of Medicine of Cincinnati. They are Dr. Anthony Matuska and Dr. Parke G. Smith, both of whom were presented the 50-Year Award of the Ohio State Medical Association.

Dr. Paul N. Ivins, Hamilton, Councilor of the First District, made the presentations. Dr. Robert E. Howard, Cincinnati, OSMA President, participated in the presentation ceremonies, as did Dr. Milford O. Rouse, Dallas, Texas, President of the AMA, and featured guest of the Society for the meeting.

Speaker for the December 12 meeting of the Academy was Dr. William W. Herman, Cleveland, instructor in pediatrics at Case Western Reserve University School of Medicine, who discussed the topic, "Required Family Life Education in the Schools." The program was jointly sponsored by the Academy and the Cincinnati Obstetrical and Gynecological Society.

Second District

(COUNCILOR: GEORGE J. SCHROER, M. D., SIDNEY)

GREENE

Dr. Cary B. Gardner was elected president of the Greene County Medical Society at the December 14 meeting at Greene Memorial Hospital in Xenia. He succeeds Dr. Richard A. Fails. Other officers for the year are Dr. R. K. Miller, vice-president; and Dr. Edward Call, secretary-treasurer.

Dr. Alan Shafer, Dayton, was speaker for the occasion and discussed the role of the pediatric surgeon in present day care of infants and children. He also described facilities at the Barney Children's Medical Center in Dayton.

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

HANCOCK

Members of the Hancock County Medical Society entertained their wives at a Christmas party and dinner on December 19 at the Findlay Country Club. Representative Jackson E. Betts was speaker for the occasion.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The calendar of the Academy of Medicine of Toledo and Lucas County contained the following features for January.

January 11 — Social hour, banquet, and program at the Commodore Perry Motor Inn; speaker, Vernon J. Forney, D. D. S., Chicago, whose topic was "Federal Health Legislation — An Aid to Private and Public Sectors in Planning and Providing Health Services."

January 17 — Dr. Thomas Tomasi, Jr., professor of medicine, State University of New York at Buffalo, spoke on the topic, "Clinical Aspects of the Dysproteinemias," at the evening meeting in the Academy Building. He also gave lectures during the day at two hospitals.

Scheduled for February 14-15 is the Inter-Hospital Postgraduate Lecture Series, the program being jointly by the Medical Advancement Trust of Maumee Valley Hospital and the Northwestern Ohio Heart Association. Lecturer will be Dr. Victor A. McKusick, chief of the Division of Medical Genetics at Johns Hopkins University School of Medicine.

Fifth District

(COUNCILOR: P. JOHN ROBECHEK, M. D., CLEVELAND)

CUYAHOGA

Ten physicians were honored for outstanding service in the profession at the January 9 meeting of the Academy of Medicine of Cleveland. Dr. P. John Robechek, Councilor of the Fifth District, presented

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50-Year Awards of the Ohio State Medical Association to the following doctors:

Jilijonas Abraitis, M. D., Russell Boyd Crawford, M. D., John A. Filak, M. D., Joseph Hornstein, M. D., William B. Landesman, M. D., Joseph D. McNemey, M. D., Earl Weldon Netherton, M. D., David Virgil Rosenberg, M. D., Hugh J. Savage, M. D., and Boris Michael Vroblevsky, M. D.

The dinner meeting was followed by a program featuring the 13th Annual Lower Lecture. Guest speaker for the occasion was Dr. Jerome W. Conn, professor of medicine, Division of Endocrinology and Metabolism, University of Michigan Medical Center, Ann Arbor.

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

Dr. Clarence Stefanski, 14 Lee Drive, Poland, a general practitioner, was honored for 50 years of service in the medical profession by the Mahoning County Medical Society Tuesday night (Dec. 19) in the Mural Building, Youngstown.

Dr. Stefanski received a certificate of distinction and a pin enrolling him in the 50-Year Club of the Ohio State Medical Association. Congratulations were offered by Dr. Edwin R. Westbrook, 6th District Councilor of the state group.

Dr. Stefanski entered the general practice of medicine in Youngstown in 1920 with an office at 20 W. Front St. For many years he has maintained an office at the present location in the Mahoning Bank Building.

Dr. Harold J. Reese, retiring president, reviewed activities of the society in 1967, noting the society had a successful antimeasles campaign and held its first annual scholarship dinner for outstanding seniors in the county's 22 high schools. Dr. Reese told the doctors the society completed its first scholarship loan during 1967 and that the year saw a code of ethics established for doctors and lawyers concerning procedures for giving medical testimony.

He said another accomplishment was active discussion and planning for eventual establishment of a medical school at Youngstown State University. — *Youngstown Vindicator.*

SUMMIT

Dr. Carroll F. Tatum, former radiologist at Akron Hospital and now associated with Medina Community Hospital, spoke on "Acro-Osteolysis" at the December 5 meeting of the Summit County Medical Society at Children's Hospital in Akron.

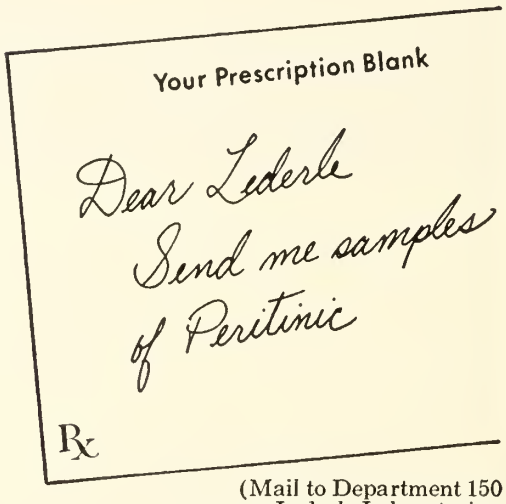
Dr. Daniel W. Mathias was installed as president at the January 3 meeting of the Summit County Medical Society in Akron. He succeeds Dr. L. V. Phillips. Dr. Marshall R. Werner is the president-elect, and Dr. Frank T. Lansden, is secretary.

TRUMBULL

Installation of officers for the current year was a feature of the January 17 meeting of the Trumbull

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Vitamin C	200 mg
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County Medical Society. Auxiliary members were special guests for the dinner and evening of dancing at the Trumbull Country Club.

Officers for 1968 are Dr. Donn F. Covert, president; Dr. L. A. Loria, president-elect; Dr. Donald S. Hall, secretary-treasurer.

Ninth District

(COUNCILOR: OSCAR W. CLARKE, M. D., GALLIPOLIS)

SCIOTO

Dr. Gilbert Micklethwaite, Portsmouth, was honored at the December meeting of the Scioto County Medical Society when he was presented the 50-Year Award of the Ohio State Medical Association.

A practitioner of long standing in Portsmouth, Dr. Micklethwaite was long active in medical organization work and is a former member of The Council of the Ohio State Medical Association, having served as Councilor of the Ninth District.

Dr. Spencer K. Miller, incoming president of the Society, made the presentation. Dr. Miller succeeds Dr. Chester H. Allen, also a former Ninth District Councilor. Dr. Philip D. Weems is the new vice-president. Dr. Erich Spiro was re-elected secretary-treasurer.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

LORAIN

Attorneys and physicians of Lorain County met Tuesday evening, January 9th, when members of the Bar Association attended the regular monthly meeting of the Medical Society at Oberlin Inn.

Beginning with a social hour and dinner, the program which followed, presented an actual trial situation on the subject of "Medical Testimony — The Doctor Witness" to a combined attendance of 132 members of the medical and legal professions. A brief Panel Discussion concluded the presentation.

Participants included Attorneys Dan Cook, Richard Horan and Ray Miraldi, of Lorain. Representing the physicians were Drs. Joseph M. Strong, Harold A. Robinson and George W. Bennett of Elyria. President Delbert L. Fischer of the Medical Society extended a vote of thanks to the participants and all who attended, for their enthusiastic interest in the program.

During a short business session, a Memorial Address in memory of Dr. John P. Rankin, of Elyria, was given by Dr. R. D. Berkebile, and the members present stood in silent tribute to their respected colleague.

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Deadline for Submission of Resolutions to Columbus Office of the Association Is March 14

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1968 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal,* must be introduced at the first session of the House of Delegates, Monday evening, May 13, at the Netherland-Hilton Hotel, Cincinnati.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 14. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

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Coming Meetings . . .

February 19-20 — "Intensive Care Units" — The American College of Physicians and the University of Cincinnati College of Medicine.

February 21 — "Implications of Community Psychiatry for State Mental Hospitals" — Cincinnati Society of Neurology and Psychiatry.

March 9-16 — San Juan Invitational — Ohio Academy of General Practice's first annual joint meeting with a sister chapter outside the continental USA — the Puerto Rico Academy of General Practice. Contact OAGP.

March 25 - May 27 — Series of Continuing Education Courses in Psychiatry — Ohio Academy of General Practice and the University of Cincinnati College of Medicine.

OSU College of Medicine

Following are postgraduate courses offered by or in collaboration with the Ohio State University College of Medicine. Details may be obtained from William G. Pace, M. D., Director, Center for Continuing Medical Education, Ohio State University College of Medicine, 320 W. Tenth Avenue, Columbus 43210.

February 14 — "Gastroenterology (Diseases of the Liver and Biliary Tract)."

March 4-5 — Eleventh Annual Postgraduate Course in Ophthalmology.

March 14 — Multiple Sclerosis Clinic Day.

March 20 — Pediatrics Invitational Clinic.

March 24 — "Sexual Problems in Clinical Practice" — OSU and the Ohio Academy of General Practice.

March 27 — "Practical Management of Infectious Diseases — 1968."

April 24 — Pulmonary Disease Seminar.

The Cleveland Clinic Foundation

The following postgraduate courses are offered by the Cleveland Clinic Educational Foundation. Details may be obtained from Walter J. Zeiter, M. D., Director of Education, 2020 East 93rd Street, Cleveland 44106.

What Goes On — K. I. O.

The Medical Foundation of Cincinnati, an affiliate of the Academy of Medicine of Cincinnati, is publishing "What Goes On — K. I. O." for distribution to physicians and medical students in the tri-state area. "What Goes On" is a physician's guide to continuing educational opportunities in Kentucky, Indiana, and Ohio. It will be published nine times a year (the first issue was distributed in January), and will present detailed chronological accounts of current and future postgraduate medical courses, meetings, and continuing educational opportunities.

The publication is made possible through the courtesy of Lederle Laboratories, a Division of American Cyanamid Co. Physicians, and executive staffs are invited to send information on future meetings to G. S. Accetta, M. D., 320 Broadway, Cincinnati, Ohio 45202 (Phone: 513-721-2345). Information for the brochure should be sent in six weeks before publication date. Inquiries in regard to distribution of "What Goes On" may also be directed to Dr. Accetta, at the foregoing address which is also the headquarters of the Academy of Medicine of Cincinnati.

Cleveland Clinic *(Contd.)*

February 28-29 — "Recent Advances in Pediatrics."

March 6-7 — "Controversies in Urology."

March 20-21 — "Current Management of Renal Disease."

March 27-28 — "Medical Progress and Its Relationship to Dentistry."

April 3-4 — "Fundamental Principles of Anesthetic Technic."

April 17-18 — "Psychiatry in General Medicine."

April 24-25 — "Laboratory Aspects of Hematology."

Ohio State Medical Association, 1968 Annual Meeting
Cincinnati, May 13 - 17

Carroll County Medical Society Fourth Annual PG Seminar

The Carroll County Medical Society has announced its Fourth Annual Postgraduate Seminar to be held on Wednesday, April 3, at the Atwood Yacht Club, Atwood Lake, Route 1, Dellroy.

The guest faculty will include Dr. Raymond Jordan, and Dr. William B. Ford, of the University of Pittsburgh School of Medicine; and Dr. Richard L. Witt and Dr. Herbert C. Flessa, of the University of Cincinnati College of Medicine.

Dr. Thomas J. Atchison, secretary of the Society, announced that American Academy of General Practice continuation study credit was authorized for the course. An all-day program for the ladies also will be provided.

Ohioan Heads New Organized Medical Tennis Group

An Ohioan is president of the American Medical Tennis Association (AMTA) which has scheduled its first organized tennis event for February 14-17 at the Holiday Parks courts in Fort Lauderdale, Florida.

Dr. William J. McGannon, Lakewood, is AMTA president. Dr. Andre S. Capi, Fort Lauderdale, is tournament chairman and has proposed a program to include men's open singles and doubles championship and singles consolation matches; and senior singles and doubles championship matches.

Any doctor of medicine may enter, whether or not he is an AMTA member. The $5 fee for each event will include prizes, cocktail party, and tennis balls. Plans are in the making for a tournament in Palm Springs, Calif., in April, and an event in connection with the American Medical Association convention in San Francisco in June.

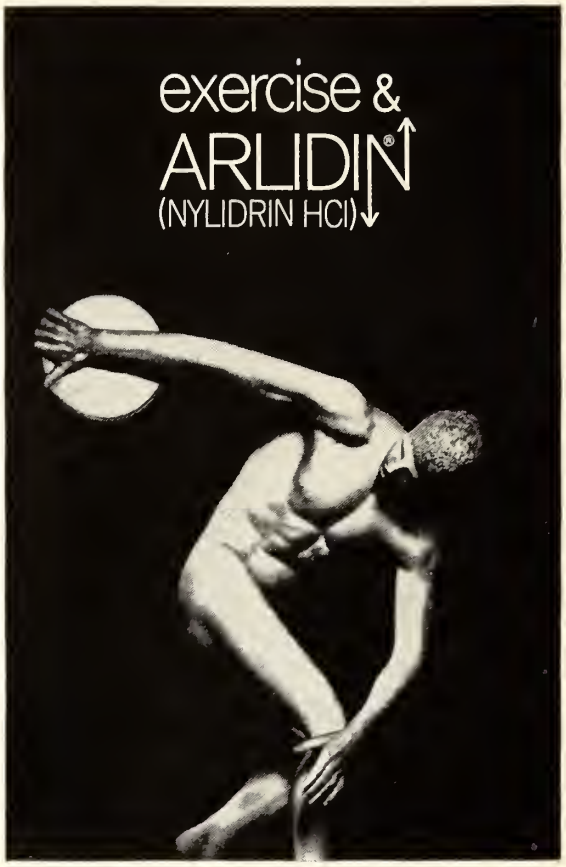
Entries may be made, or details obtained, by writing Bill Drake, Rx Golf & Travel Magazine, P. O. Box 25125, Oklahoma City, Oklahoma.

OSU Pharmacy Professor Gets Top Award in His Field

The American Society of Hospital Pharmacists has announced that its highest award will be given this year to Clifton J. Latiolais, assistant professor of pharmacy at Ohio State University and director of the pharmacy at University Hospitals.

The Harvey A. K. Whitney Lecture Award is given annually for significant contributions to hospital pharmacy. The award will be presented to Latiolais at the annual meeting of the society in May.

Latiolais is coauthor of two books, has served as president of both the American and Ohio Societies of Hospital Pharmacists, and is a contributing editor to the *Journal of American Hospital Pharmacy.*



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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

BY NOW, all of you should be familiar with the talents and tremendous capacities of our state President, Mrs. J. Paul Sauvageot. I feel that a contribution of hers during the Fall months of this past year deserves recognition in this column. For some time, the National Auxiliary has held four regional workshops for state presidents, presidents-elect and certain committee chairmen. For the first time, however, this past Fall of 1967 emphasized a new angle: Editors of state auxiliary publications were invited to participate in these regional workshops. Ludel Sauvageot (a member of the staff of *MD's Wife)* was asked to do a publications workshop and discuss content and writing. She has had considerable and successful experience in the field of journalism and public relations (she also served as editor of our own *Medical Auxiliary News).*

These recent workshops were held in Chicago, Atlanta, Philadelphia, and Denver. To me, the recognition of the need for giving help to auxiliary women editors is a tremendous step forward — most of the women editors have had no journalism background. The Ohio Auxiliary has every reason to be proud that its President was called upon by National to participate in this important "first."

Mental Health

High among auxiliary projects is the tremendously important Mental Health program. Mrs. Daniel S. Wolff, state chairman, has said recently: "Hopefully every auxiliary will devote at least one program to Mental Health during this auxiliary year — hopefully every auxiliary will make it a community effort . . ." National has suggested this year that attention be focused on "Study of Adolescence and Early Adulthood." In a special communication to local mental health chairmen, Mrs. Wolff reminded these women that according to House Bill 648, passed by the Ohio Legislature this past summer, "a Community Mental Health and Retardation Program governed by a Board of 9 to 15 members (one-third appointed by the Commissioner of Mental Hygiene and two-thirds by the County Commissioners) must be started in any county with a population of 50,000 or above."

Mrs. Wolff suggested these guidelines: Work with and through your community services chairman; work with your local Mental Health Association; be sure you have the approval of your County Medical Society. She also listed these suggestions for special programs: 1) Panel discussions — try to have an equal number of youngsters and adults; 2) Debates — choose subjects of interest to teen-agers such as "Why I can — or cannot — talk with my parents"; 3) Speakers — use people in the mental health field from your community; 4) Presentations on the resources available in your community for the support of troubled people; 5) Film showings — good films are available and may be obtained by writing to the AMA Film Library (all are 16 mm., sound, color or black and white) — two particularly good films are recommended — "Who Cares About Jamie" and "Children on the Move"; 6) Programs based on books, pamphlets and articles — the AMA office has package programs available; 7) Recordings — "Mirror to the Mind" series available

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from AMA; 8) Play presentations — which may be enacted by high school drama clubs or with the cooperation of speech teachers.

Mental Health is a project any auxiliary can participate in — be it the biggest — or the smallest — of groups!

Here and There

The **Columbiana County Auxiliary** played hostess to its County Medical Society in December when the women entertained with a Christmas dinner party — an annual and happy event. Covers were laid for 75 at the Salem Golf Club. A color scheme of pink predominated the many beautiful and varied decorations. Favors were Santa boxed-matches for the men and soap embellished with pink angels for the women. Corsages of carnations were sold for the benefit of AMA-ERF. The entertainment featured the Salem Community Players in "Here We Are." Dr. J. R. Moorehead led the caroling, with Dr. Leonard Pritchard at the organ. Dr. R. J. McConnor was a delightful Santa Claus. The committee in charge of arrangements included: Mrs. Peter Cibula, chairman; Mrs. Paul Beaver, Mrs. Leonard Pritchard, Mrs. Chester DeWalt and Mrs. James Moorehead.

The group's November meeting was held at the home of Mrs. W. F. Stevenson and featured the bringing and wrapping of Christmas toys for the County Welfare Department's foster children. Mrs. K. S. Ulicny, president, conducted the business session. Mrs. P. W. Conrad, membership chairman, reported 63 paid-up members. Refreshments rounded out the afternoon with Mrs. Virgil Hart serving at the tea table. Mrs. Fred Crowgey and Mrs. R. T. Holzbach were co-hostesses.

Real Bargain!

Where? At **Cuyahoga County's** Bargain Boutique — that's where! Early in January, the *Cleveland Press* featured an exceptionally fine story on the auxiliary's new Bargain Boutique at Fairhill Psychiatric Hospital, operated to brighten the patients' wardrobes **and** morale, and to help raise money for a special project. The shop offers used clothing priced from a nickel to a dollar. Although housed in a basement, the boutique has been fixed attractively to resemble a good specialty shop. Patients help the auxiliary volunteers mend and press garments and may shop each Wednesday and Thursday afternoon. Profits go into the hospital's trust fund to purchase recreational and occupational therapy equipment.

"The Auxiliary is always looking for new mental health projects," said shop chairman, Mrs. Gordon E. Gustafson who also is president of the Women's Council to the Cleveland Mental Health Association. The shop is open to both resident patients and outpatients and clothing is provided free to those unable to pay. Much of the used clothing is donated by auxiliary members, although a public appeal for such apparel has resulted in a generous response. Mr. Robert A. Lang, executive secretary to the Academy of Medicine of Cleveland and the Cuyahoga County Medical Society, wrote Mrs. R. R. Gould, auxiliary president, recently and commented: "This kind of activity is first rate public relations because it grows out of a real public service rather than being some dreamed-up activity to get attention . . ." I echo his sentiments!

From Cuyahoga's "Back Seat," (its excellent News Letter) I glean the following tid-bits: A new Living Room Learning Course, "Voices from Latin America," started on January 12 for an eight-week "run." It covers literary expressions of contemporary thought and feeling, cultural heritage and its influence on current social ideas. There was a midwinter luncheon meeting on January 26 at Higbee's Auditorium, with the spotlight focused on Family Life Education. The purpose of this meeting was to provide an opportunity for classroom teachers, superintendents and school physicians to learn what will be taught on this subject in their schools by specially-trained teachers who go into the classrooms. Mrs. W. Marlin Butts of the Family Health Association, chief instructor of these teachers, interpreted the aims of this county-wide program. I hope to have additional information on this in next month's issue.

What's Doing

The early December meeting of the **Huron County** group was particularly meaningful. Members packed boxes for servicemen in Vietnam and took them to the post office for mailing. Christmas boutonnieres were presented to the membership. The meeting was held in the home of Mrs. Earl McLoney. Mrs. Robert Higgins assisted the hostess.

The annual Christmas party given by the **Lawrence County** auxiliary for its Medical Society honored Dr. Chester A. Casey who marked up his fiftieth year in the practice of medicine. Dr. and Mrs. Casey were the special guests at the dinner party at the Ashland-Ironton Holiday Inn. Dr. Ralph Massie who made the presentation of the 50-year pin remarked: "The fifty years of being an M. D. is not all that calls for this honor or recognition. We also want to thank you, Dr. Casey, yes, and praise you, for what you have done for our community in so many different ways." Following the dinner, Dr. and Mrs. Burton Payne entertained the auxiliary members and their husbands at their home.

The **Trumbull County** group holds an annual Christmas Coffee. This year there were some special guests—honorary members and wives of resident physicians. During the brief business meeting, delegates and alternates to the State Convention in May were elected and monetary donations made to Project Hope, Trumbull Memorial, and St. Joseph's hospitals. Mrs. E. G. Kyle and Mrs. J. D. Knox presided

at the beautifully appointed table laden with traditional delicacies. Hostesses included: Mrs. George Mokris, Mrs. L. A. Gleitsman, Mrs. B. J. Tabet, Mrs. A. Smits and Mrs. W. I. Droba.

Scioto County's auxiliary Christmas party was held at the home of Dr. and Mrs. Jerome Rini. There were many beautiful and unusual touches in the decorative scheme. The traditional eggnog was served prior to the dessert luncheon. The afternoon's entertainment featured an exquisite young woman from Thailand who discussed her country and showed colored slides that were, in many instances, almost breath-taking. Mrs. Clyde Hurst, president, conducted the short business session. The group sent its annual Christmas Food Basket to the County Home. Toys brought by the members to this Holiday meeting were turned over to the Salvation Army. Those assisting Mrs. Rini at the dessert luncheon included: Mrs. Carl Braunlin, Mrs. Louis Chaboudy, Mrs. George Martin, Mrs. Alden Oakes and Mrs. Harlan Williams.

This reporter would like to express her deep thanks to **Muskingum** and **Tuscarawas** Counties whose November meetings she visited and at which she discussed the dramatic story of the X-Ray.

Cincinnati Team Participates in Broad Thyroid Disease Study

An extensive study in which a team from the University of Cincinnati participated indicates that the use of radioactive iodine in treatment of patients with thyroid disease does not cause leukemia. The study group included 36,000 patients in 26 medical centers, including facilities associated with the University of Cincinnati College of Medicine.

The preliminary report states that hyperthyroid patients treated with radioiodine show no increase in leukemia rate over patients with the same disease who have been treated surgically.

The Cooperative Thyrotoxicosis Therapy Follow-Up Study, initiated in 1961 by the National Center for Radiological Health, U. S. Public Health Service, has issued a preliminary report on the incidence of leukemia following treatment of hyperthyroidism.

Dr. George E. Thoma, St. Louis College of Medicine, and Dr. Eugene L. Saenger, University of Cincinnati College of Medicine, made the announcement. Dr. Saenger is professor of radiology and director of the University's Radioisotope Laboratory, located at Cincinnati General Hospital.

The cooperative study was based on information of approximately 22,000 patients who received radioiodine and 14,000 treated surgically or with drugs. Patients in the study were treated between 1946 and 1964.

Selective Service Boosts Its Call for MDs

Following is the text of Operations Bulletin No. 318, issued on December 28, 1967, by General Lewis B. Hershey, director of the National Selective Service System, on the subject, "Reclassification and Special Report of Doctors of Medicine":

"1. Information received from the Department of Defense indicates that the Selective Service System will receive a special call for approximately 1100 Doctors of Medicine to be delivered during the summer of 1968.

"2. In preparation for this special call local boards are requested to immediately reopen and consider anew the classifications of physician interns who are in Class II-A and whose internship will terminate during 1968. Physician interns who have been appointed in the Public Health Service CORD Program may be retained in Class II-A without reopening classifications.

"3. The size of this special call indicates that it will be necessary to call all available physicians just completing their internships during 1968, as well as other available physicians."

Emphysema-type Study Clinic Is Set Up in Arizona

An outpatient clinic to develop and evaluate services for emphysema and chronic bronchitis patients is being set up at the Tucson, Arizona, Medical Center under a contract awarded by the National Center for Chronic Disease Control, U. S. Public Health Service.

Emphysema and chronic bronchitis have become urgent health problems throughout the country, and pose special problems for Arizona where the death rate from these diseases is generally three to four times as great as the national rate. In Arizona, chronic chest diseases rank as the fourth leading cause of death, while they rank tenth in the U. S.

Population movement may be more responsible for this excess number of chronic respiratory disease deaths than environmental factors or special susceptibility. The percentage of deaths in Arizona attributed to chronic respiratory disease is significantly higher for patients born in other States than for native Arizonians, not because native Arizonians are less susceptible, but because such a preponderance of respiratory patients living in the State migrated there from other parts of the country, seeking relief from their breathing difficulties.

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3939 Monroe St

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Box (insert number), c/o The Ohio State Medical Journal.
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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street. Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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(Continued from Previous Page)

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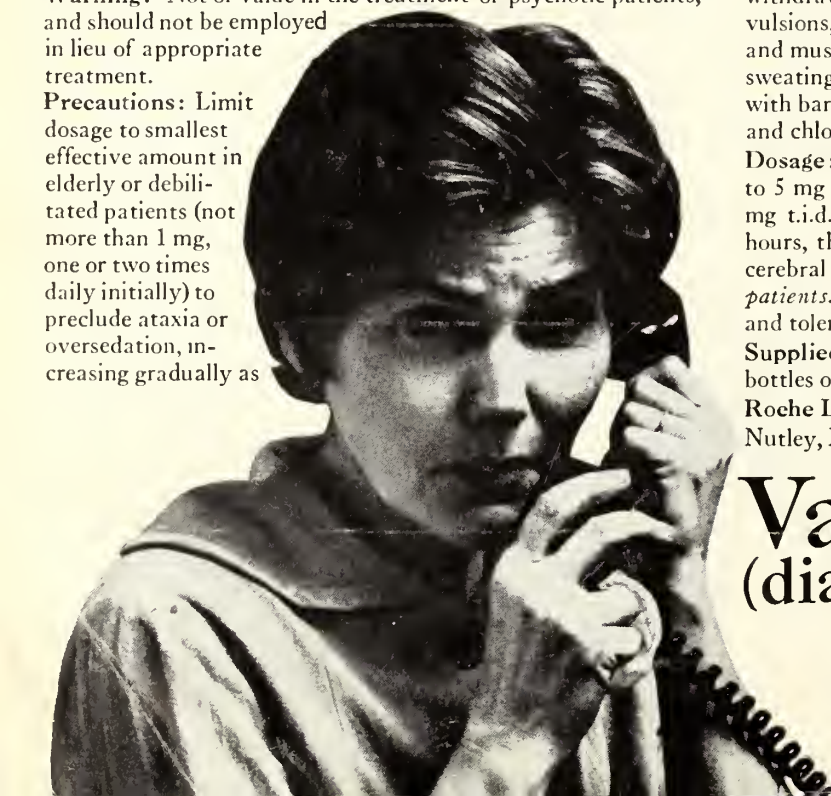


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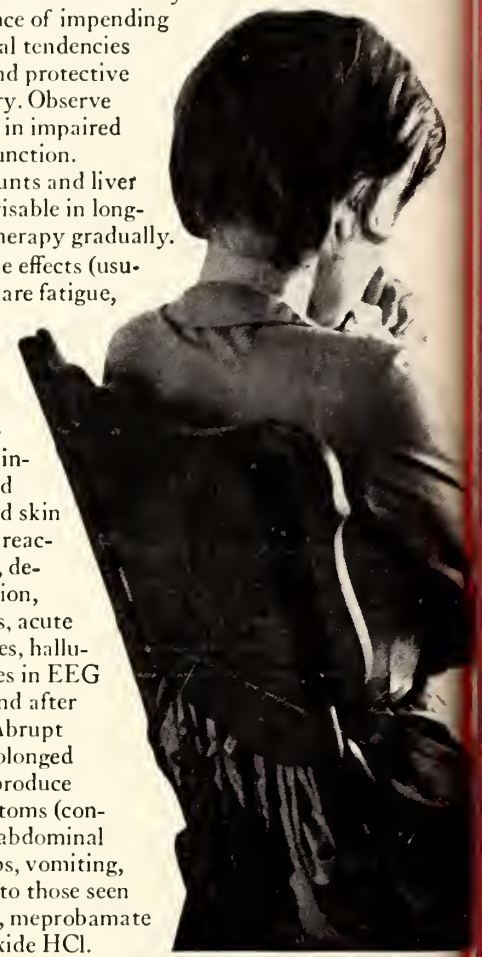
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Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects–particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.



Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.



Dosage: *Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

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OHIO STATE MEDICAL ASSOCIATION 1835

The OHIO STATE MEDICAL Journal

Published By The Ohio State Medical Association

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BOSTON
25 MAR 1968

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CH 1968
64 ★ NUMBER 3

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VOL. 64 MARCH, 1968 No. 3

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Address All Correspondence:
The Ohio State Medical Journal
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Columbus, Ohio 43215

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Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

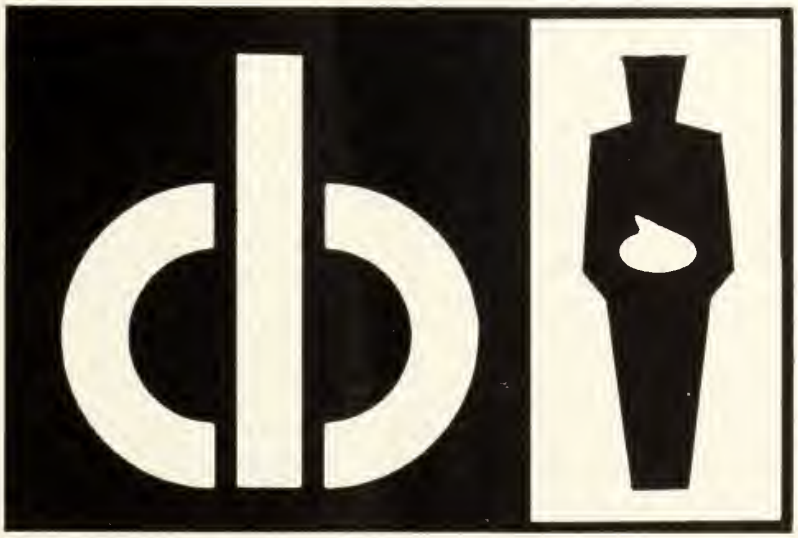
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Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
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Dr. Hudson Accepts Post on AMA Staff in Chicago

Dr. Charles L. Hudson, Cleveland, Immediate Past President of the American Medical Association, and a Past President of the Ohio State Medical Association, was named director of the AMA's Socio-Economic Activities Division on January 1. He succeeds Dr. Howard W. Doan, who has resigned from the AMA staff.

Dr. Hudson, formerly in the private practice of internal medicine in Cleveland, in recent years has been associated with the Department of Internal Medicine of the Cleveland Clinic, and has been associate professor of clinical medicine at Case Western Reserve University School of Medicine.

The AMA division he heads develops AMA programs concerned with governmental medical services, environmental and occupational health, hospital and medical facilities, and health education.

Dr. Hudson, educated in Michigan, received his A. B. degree magna cum laude from Alma College and his M. D. degree cum laude from the University of Michigan.

His internship and residency at the University Hospitals of Cleveland were followed by a two-year research fellowship in the Dept. of Pharmacology at the University of Pennsylvania. He then returned to the University Hospitals as chief resident in medicine.

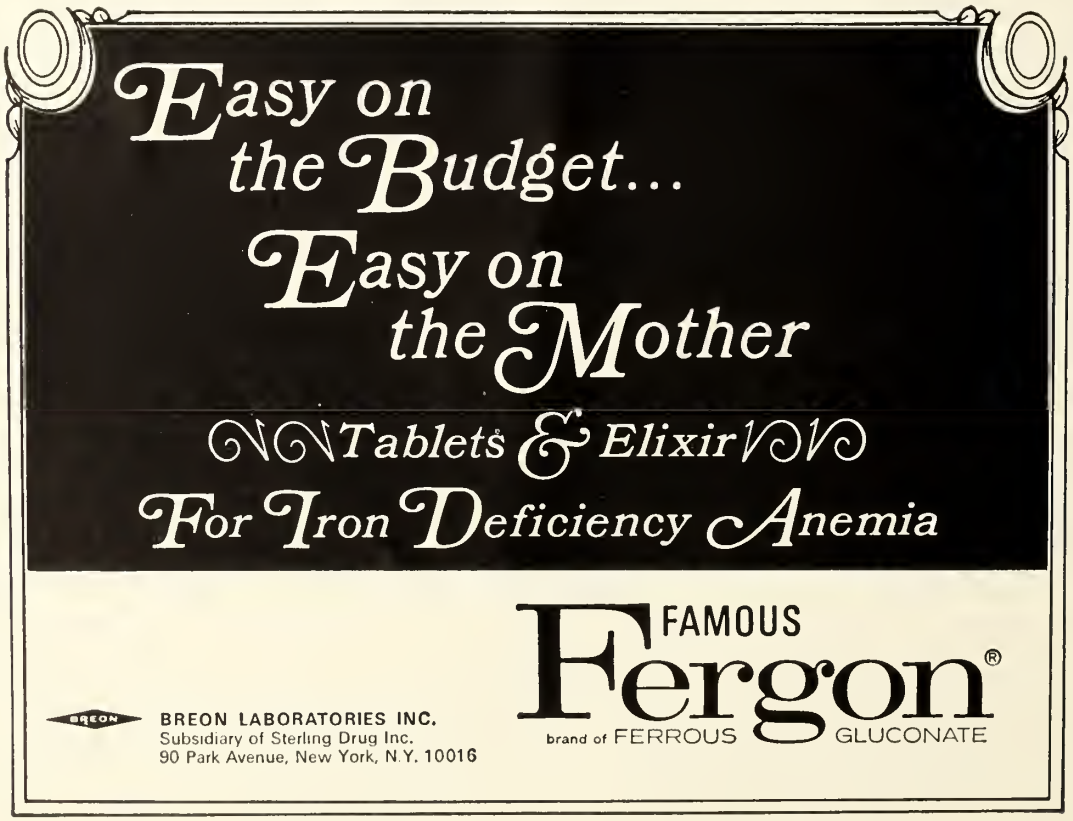
During World War II, he was a lieutenant colonel in the Army hospital service overseas.

Dr. Hudson is a past president of the Academy of Medicine of Cleveland, past president and former chairman of the Board of Trustees of the Cleveland Medical Library Association, a trustee of the Cleveland Welfare Federation and a member of its various committees.

"Guidelines" Implement Rural Medical Emergency Plan

Complementing the five-point rural emergency medical services plan recently developed by the AMA's Council on Rural Health is its vital sequel — "Guidelines for Implementation . . ."

Its four pages contain ideas relative to organizational structure, mechanisms by which presently existing emergency systems may be evaluated and general recommendations with regard to first aid, communications and transportation. Single copies may be obtained — at no cost — from the Council on Rural Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.



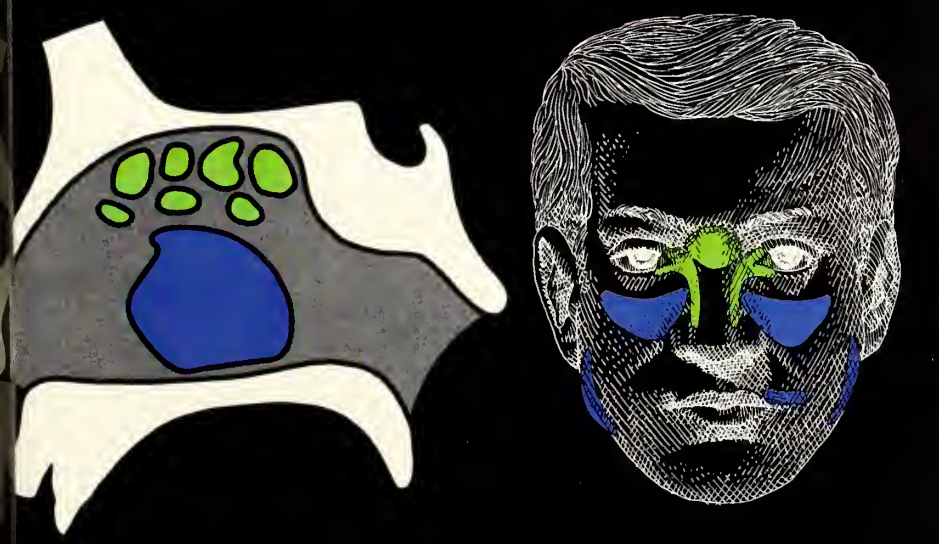
Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

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Dosage: Adults—2 tablets every 4 hours.

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OSU Will Test Endurance in Hyperbaric Chamber

Can a man safely live in a chamber 1,000 feet beneath the sea for as long as 30 days without surfacing?

Members of the Department of Preventive Medicine at Ohio State University are optimistic about such an undertaking. They plan research to seek a definite answer to the question when their new hyperbaric chamber is installed at Wiseman Hall in the University's medical complex.

The high-pressure chamber will be used in this project to simulate intense sea pressure, which increases at a rate of 15 pounds per square inch for every 33 feet of water depth.

The cylindrical chamber is about 30 feet long. Because experiments will require an internal pressure of about 2,000 pounds per square inch, the chamber will undergo a series of safety tests before actual research begins next summer.

Other studies have put men down to levels of 100 and 200 feet for two-week periods without harm, and several big industries, along with the Navy, are experimenting with hyperbaric chambers, the researchers report.

The first experiments in the chamber will involve small animals and will gradually progress to the use of human volunteers.

On Estimate of Tax Liability Check the SS Maximum

A national business newsletter points out that on the Declaration of Estimated Tax (Form 1040ES), an error appears in regard to the maximum social security tax liability for self-employed persons and others who must file estimated tax forms. The form shows the maximum social security tax as $422.40. It should be $499.20.

An explanation may be found in the fact that forms were printed before passage of the Social Security Amendments of 1967, which raised to $7800 the base on which taxpayers must pay social security taxes.

Ethics and Gifts

A physician may not accept a gift such as a radio, compact refrigerator, or the like from a manufacturer or a distributor of drugs, remedies, appliances or services for prescribing these products for his patients. According to the AMA Judicial Council opinion adopted in November, 1967, this practice amounts to rebating.

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Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

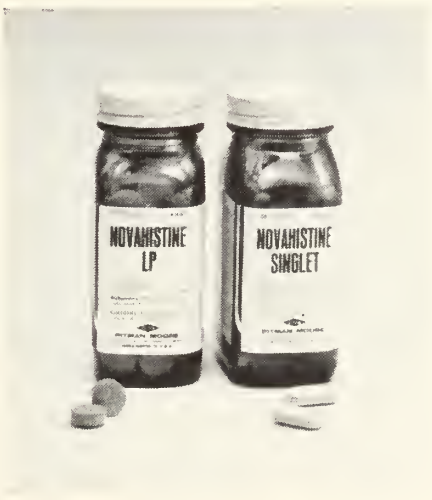
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



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Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



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A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444



e see Brief Summary xt page.

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Brief Summary

DESOXYN® Gradumet®
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DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Physicians Will Be Requested to Aid in National VD Survey

The American Medical Association has announced that on July 1, 1968, all practicing physicians in the U. S. will receive a questionnaire asking the number of cases in infectious syphilis, other stages of syphilis and gonorrhea treated by them from April 1 through June 30, 1968.

This survey, entitled, "National Survey of VD Incidence," is a repeat of a similar 1962 poll and is sponsored jointly by the American Medical Association, the American Osteopathic Association, the National Medical Association, American Social Health Association in cooperation with the Public Health Service.

Current estimates show that VD is infecting Americans at the alarming rate of 1,100,000 cases a year and is now the nation's most urgent communicable disease problem, the AMA reported. Indications are that private physician reporting has increased considerably since the 1962 survey, which showed the level of reporting to be only 11 per cent of the infectious cases treated. The 1968 survey should determine the extent of the increase.

The questionnaire card requires no signature and replies of individual physicians will not be identified by name. Results of the survey will be published nationally by the sponsoring organizations.

Cleveland Physician Will Speak At National EEG Meeting

A continuation course in Clinical Electroencephalography will be held September 9-11, 1968, in San Francisco, California. The course is designed as a basic review of the applications of the EEG to clinical medical practice, and is sponsored by the American EEG Society (aided by a grant from the National Center for Chronic Disease Control, U. S. Public Health Service).

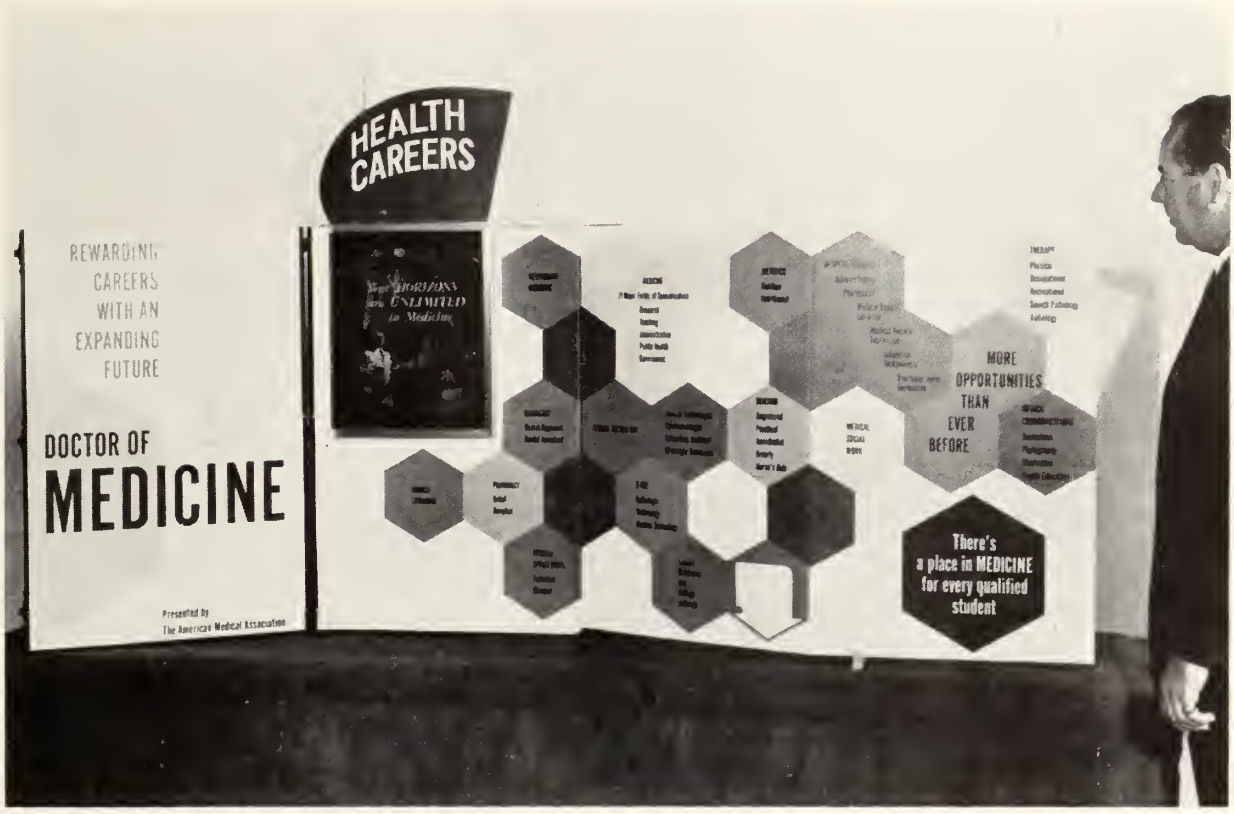
The Faculty will include Dr. Charles E. Henry, of Cleveland.

Inquiries about further details of the course or registration procedure should be addressed to Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minnesota 55901.

State Medical Board Licenses 76 MDs by Endorsement

The State Medical Board of Ohio recently issued a list of 76 Doctors of Medicine who have been licensed to practice in Ohio through endorsement of their licenses to practice in other states with which Ohio has reciprocity, or through certification by the National Board of Medical Examiners.

New Exhibit on Medical Careers



This new, lightweight AMA exhibit, designed for use in medical society and auxiliary careers programs and health fairs, emphasizes the wide variety of careers opportunities in medicine and allied fields.

Streamlined, Lightweight Exhibit Now Available from AMA

To satisfy a growing demand for a lightweight exhibit appealing to the broad range of medical careers, rather than one emphasizing only physician careers, the American Medical Association has developed a colorful tabletop exhibit, "Health Careers."

Four of these exhibits are now available from the Exhibits Section, Program Services Department, for Careers Day programs in schools, health fairs, state fairs, and other programs.

Featuring a color transparency of the cover of the AMA's careers handbook, Horizons Unlimited, the full-color folding exhibit, which is eight feet wide and 40 inches tall, calls attention to the fields of specialization and other specialized areas of interest open to Doctors of Medicine and more than 20 principal allied fields ranging from medical librarian to dentistry.

"There's a place in medicine for every qualified student," the exhibit emphasizes.

Since "Health Careers" weighs only 120 pounds, less than half that of the exhibit "Medicine as a Career," shipping costs correspondingly are reduced. Recipients must pay round-trip shipping costs. Those desiring to order the exhibit should give a minimum of 30 days' notice, although several months is preferable. Loan orders will be filled on a "first come, first served" basis.

Orders for suitable AMA careers literature to be displayed at the exhibit should either accompany exhibit orders or be placed separately with the Program Services Department.

Assistant Director Is Named for Ohio Department of Health

Dr. Thomas A. Gardner has been appointed assistant director of the Ohio Department of Health, it was announced in January by Dr. Emmett W. Arnold, director. A career public health officer, Dr. Gardner has been in the Columbus headquarters of the Department since 1958 as chief of the Bureau of Local Services. Prior health department service included that as district health officer in the Department's Southwest District, centered in Dayton.

Physician's Bookshelf . . .

The Prevention of Highway Injury: Edited by Melvin L. Selzer, M. D., Paul W. Gikas, M. D., and Donald F. Huelke, Ph. D.; published by Highway Safety Research Institute, University of Michigan, Ann Arbor, Mich., 48108; price $6.50. In hardback book form, this volume contained proceedings of a symposium held April, 1967, in honor of the University of Michigan's Sesquicentennial Celebration and sponsored by the University's Medical School and Highway Safety Research Institute.

Atlas of Diagnostic Techniques and Treatment of Retinal Detachment, by William H. Havener, M. D., M. S. (Ophth.), professor, Department of Ophthalmology, Ohio State University, and Sallie Gloeckner, medical artist, Department of Ophthalmology, OSU Hospital; the C. V. Mosby Company, St. Louis; price $18.00. A narrative description with some 80 plates of drawings.

Cellular Aspects of Developmental Pathology, by Robert P. Bolande, M. D., associate clinical professor of pathology and senior clinical instructor in pediatrics, Case Western Reserve University School of Medicine; published by Lea & Febiger Publishers, 600 Washington Square, Philadelphia, Pa. 19106; price $16.50. The author approaches the subject from a cellular patho-biologic point of view. He presents newer knowledge in cell biology, ultrastructure and histochemistry, weaving in many of the new concepts in the field of developmental biology as they relate to the pathogenesis of diseases considered.

Program for Anesthesiologists Scheduled in Cleveland

The Division of Anesthesia of Cleveland Metropolitan General Hospital, and Case Western Reserve University School of Medicine will sponsor a one day conference on **The Role of the Anesthesiologist in the Management of Head Injuries** on Saturday, March 30, 1968, from 9 A. M. to 3:30 P. M., to be held at Cleveland Metropolitan General Hospital. Anesthesiologists and other interested physicians, especially those specializing in neurology and neurosurgery are invited to attend.

Please address all inquiries to: Dr. Maurice S. Albin, Program Chairman, Cleveland Metropolitan General Hospital, 3395 Scranton Rd., Cleveland, Ohio 44109.

★

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COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient' sodium excretion is greatly enhanced. Yet potassium loss is low

The therapeutic action is smooth, and persits for a full 24 hours With Enduron you can prescribe convenient once-a-day dosag without skimping your patients on day-long thiazide effectiveness

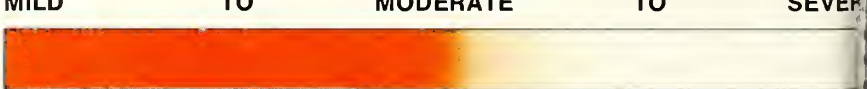
Of course, as with all thiazides, supplemental dietary potassiur should also be considered.

Use Enduron as a basic therapy in patients with mild to moc erate hypertension. A single 5-mg. tablet each day is ample i most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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ENDURONYL®

ETHYCLOTHIAZIDE 5 mg. with
SERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



PARGYLINE

METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

8010

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amendable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

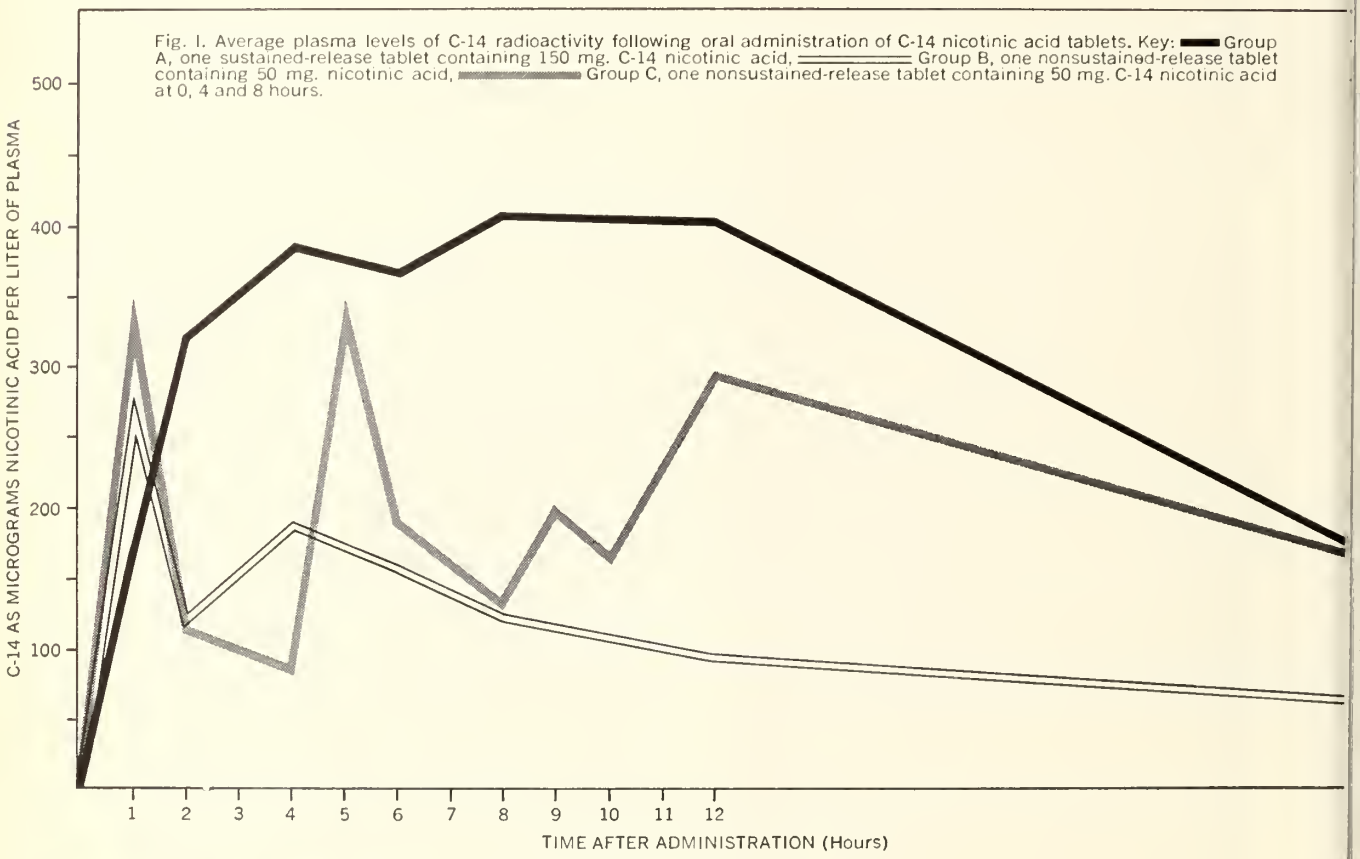
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TM-TRADEMARK

Sustained circulatory, respirator
and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be con tinuous on a daily dose of only one Geroniazol TT tab let every 12 hours.

The gradual release of nicotinic acid in Geroniazo TT will provide the well-known peripheral vasodilata tion needed in patients with deficient circulation an with a minimum amount (if any) of "flushing." Also cerebrovascular circulation is complemented by pen tylenetetrazol, long-established as a cerebral and res piratory stimulant.

Geroniazol TT improves the typical, unfortunate signs of senile confusion. Patients become more aler

ged and debilitated

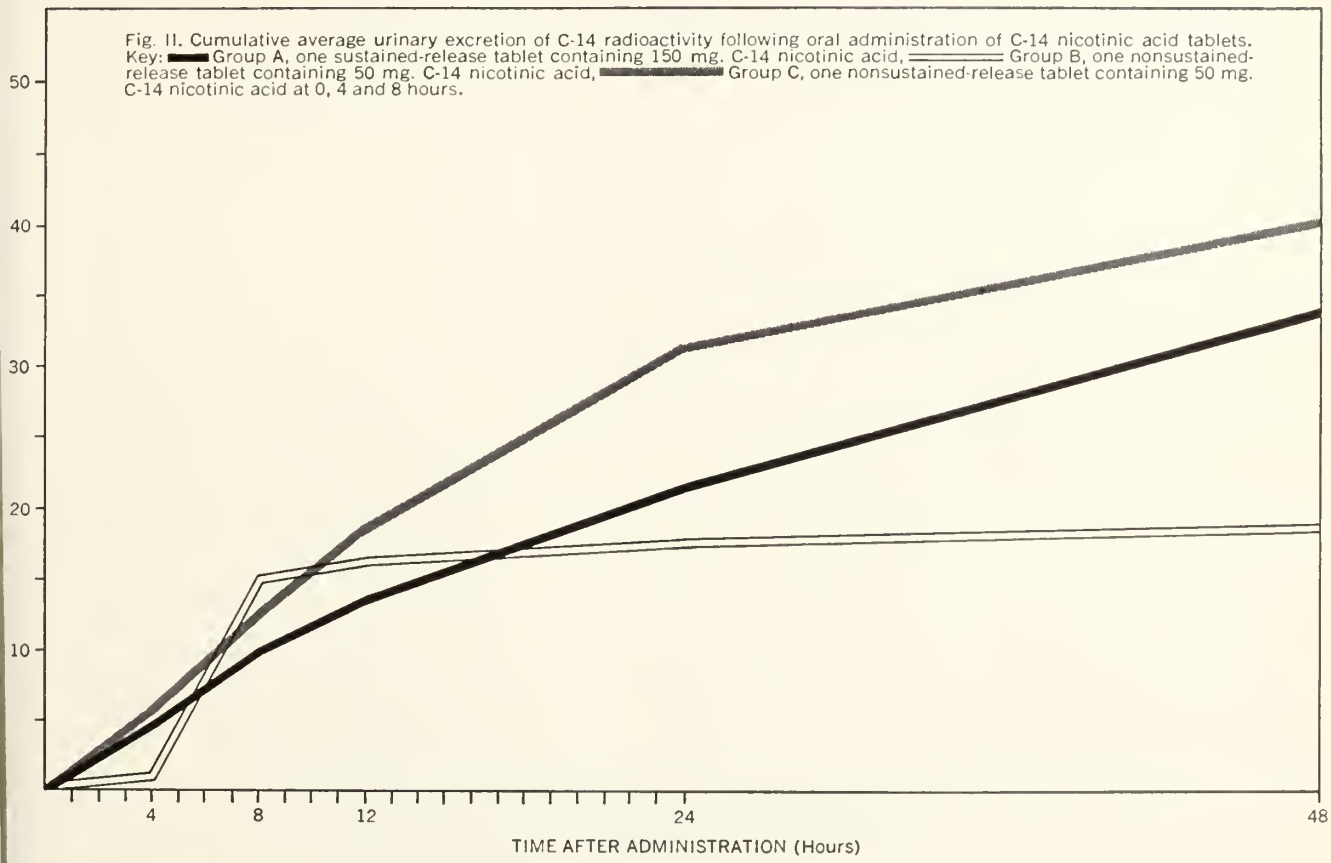


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

s confused and moody. Personal care, memory, otional stability, social attention improve. Fatigue, athy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will mit your patients to enjoy the benefits of time-longed nicotinic acid/pentylenetetrazol therapy, an economical price. Dosage is only one tablet every hours.

ntraindications: There are no known contraindica-ns.

ecautions: Exercise caution when treating patients h a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"

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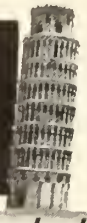
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Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg
Riboflavin	5 mg.

***Dose:* 2 tablets daily.**
***Available:* Bottles of 60, 500.**

Write for literature and samples:

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2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

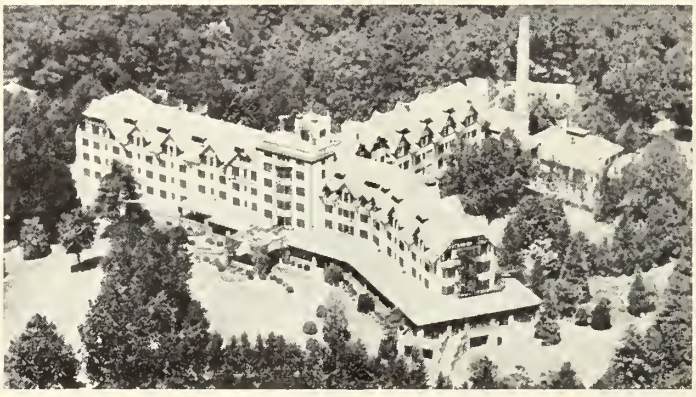
Android—E

Each Tablet Contains:

Methyl Testosterone	2.5 mg
Ethinyl Estradiol	.002 mg
Thyroid Ext. (1/6 gr.)	10 mg
Thiamine Hydrochloride	10 mg
Glutamic Acid	50 mg

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen: only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE.** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Appalachian Hall • Established 1916 Asheville, North Carolina



An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation. There are ample facilities for classification of patients

Insulin coma, electroshock, psychotherapy, occupational and recreational therapy are employed. The hospital is equipped with complete laboratory facilities, including electroencephalography and x-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town in the beautiful Smoky Mountain Range, an ideal location for rehabilitation.

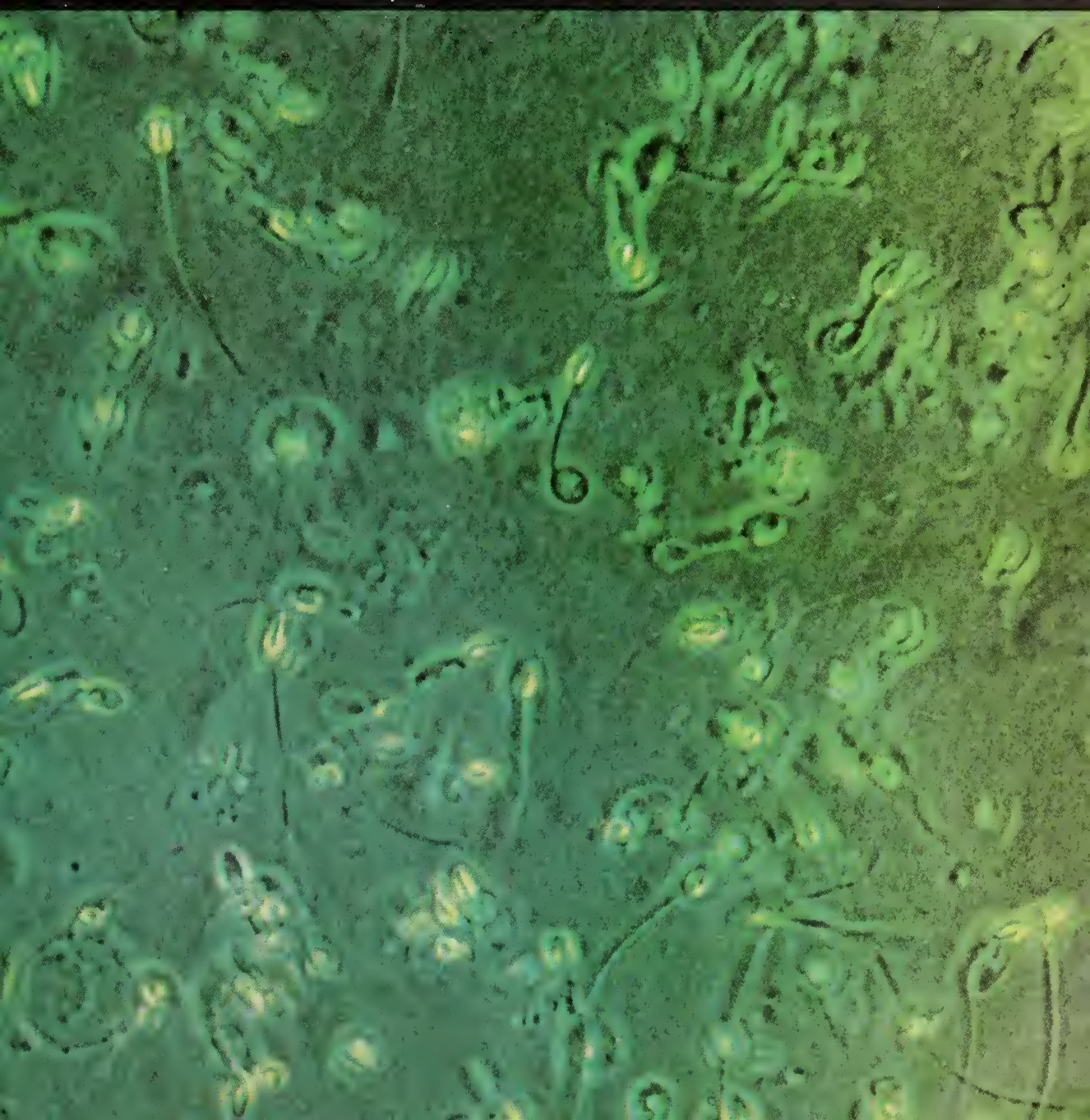
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For rates and further information write APPALACHIAN HALL, Asheville, N. C.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occu rence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. T age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy whe relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receivin oral contraceptives: nausea, vomi ing, gastrointestinal symptoms (s as abdominal cramps and bloatin breakthrough bleeding, spotting, change in menstrual flow, amenor rhea, edema, chloasma or melasm breast changes (tenderness, enlar ment and secretion), change in w (increase or decrease), changes in cervical erosion and cervical secre suppression of lactation when gi immediately postpartum, cholest jaundice, migraine, rash (allergic rise in blood pressure in susceptib individuals, mental depression.

Although the following side effect have been reported in users of ora contraceptives, no cause and effec relationship has been established anovulation post-treatment, premenstrual-like syndrome, cha in libido, changes in appetite, cyst like syndrome, headache, nervous dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema n sum, hemorrhagic eruption, itch

The following occurrences have b observed in users of oral contrace tives (a cause and effect relations has been neither established nor proved): thrombophlebitis, pulmo embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfo-bromophthalein and other hepati function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid func tion (increase in PBI and butanol extractable protein-bound iodine decrease in T^3 values), metyrapon test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

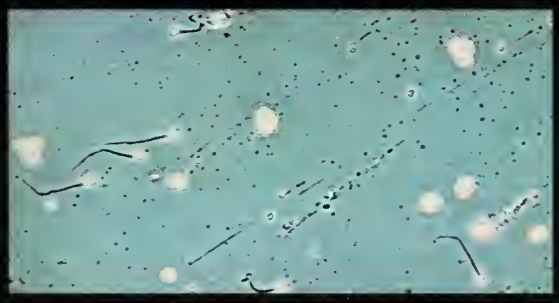
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

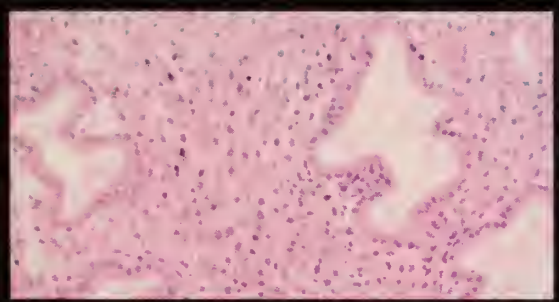
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

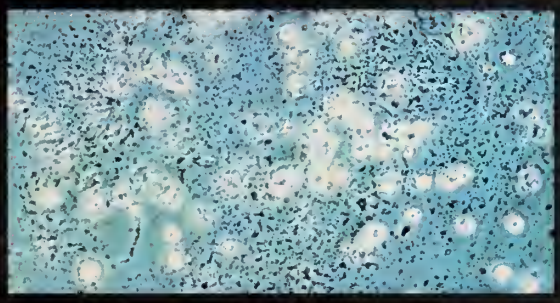


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

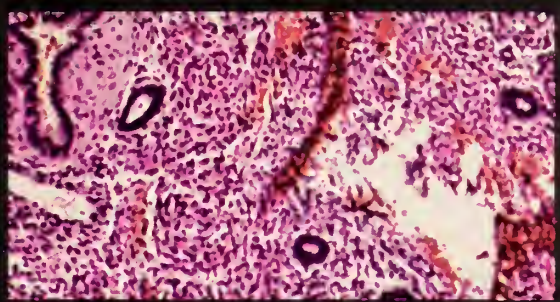
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

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(norethindrone 1mg. & mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
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Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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Prescribing Infarmatian: Composition: Eoch white, beveled, compressed tablet contoins: Quinine Sulfote 260 mg. ond Aminophylline 195 mg. **Contraindicatian:** QUINAMM is controindicoted in pregnoncy becouse of its quinine content. **Precautions:** Aminophylline moy produce intestinol cromps in some instances, ond quinine may produce symptoms of cinchonism, such os tinnitus, dizziness, and gostrointestinol disturbonce. Discontinue use if ringing in the eors, deofness, skin rosh, or visual disturbonces occur. **Dosage:** One toblet upon retiring. Where necessory, dosage moy be increased to one toblet following the evening meol ond one toblet upon retiring. **Supplied:** Bottles of 100 and 500 toblets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et ol.: Med. Times, 87:818, 1959. 6/67 Q-706A

Cleveland Study on Immunity . . .

Extensive Research by Western Reserve Team Throws Light On Extent of Children's Effective Immunity in the Area

WHETHER present vaccination programs are protecting all children is being investigated in a series of studies in Cleveland by pediatricians in the Case Western Reserve University School of Medicine. In the course of this work they are also examining the relationship of family income to the use of medical care.

A community's medical care should be judged, says Dr. Frederick C. Robbins, dean of the Case Western Reserve University School of Medicine and initiator of this project, not only by the quality of its doctors and hospitals, and their availability, but also by the willingness of the people to use them. The comparatively low utilization by the poorest families of the "free" medical care available to them has been previously noted by public health observers.

In addition to looking for the possible gaps in established immunization programs, the Case Western Reserve scientists are also testing the effectiveness of, and need for, some of the new vaccines — against polio, measles, German measles, and mumps. Physicians do not yet know for how long these vaccines keep a child immune.

To answer the medical as well as social questions they have raised, the scientists are analyzing blood samples taken from close to 5,000 children and questionnaires filled in by their parents. The blood shows the child's immunity or antibody level to different diseases. The questionnaire tells if and when he was vaccinated, also some of his medical and family history.

If he needs further immunization, his own physician or parents are notified. If he has no physician, the staff arranges for the necessary vaccinations.

Over a five-year period the investigators have gone into three widely different parts of Cleveland: Shaker Heights, long-established suburb of middle- and upper-income families; the Hough area, inner-city ghetto; and Parma, typical of new and rapidly growing middle-income suburbs. The information provided by these studies, which are supported by the U. S. Public Health Service, is expected to hold true for children in other cities of the United States as well.

More studies inside Cleveland (rather than the suburbs) are planned for this project, inasmuch as one of its objectives is to learn whether the inner city children are receiving the same protection from disease as those in the rest of the city.

Results

Up to now remarkably good levels of immunization have been found both in the affluent suburbs and the Hough area. Although the one Hough area study has not yet been completed, it appears that the majority of children in this admittedly limited sampling are getting good preventive medicine. A high rate of immunity to tetanus, for example, suggests that even those children who may have been taken to a clinic only occasionally for check-up or treatment are being inoculated with the now standard diphtheria-pertussis-tetanus vaccine.

About the Booster Dose

Of the three metropolitan areas in which studies were made, Shaker Heights has already provided useful data on polio vaccination. In this suburb, where children received the polio vaccine orally, the scientists began in 1962, investigating the immunity of several hundred school children to the three types of polio and whether, for lasting protection, the first series of vaccine should be supplemented with "boosters." This is a question for which health authorities everywhere would like a definitive answer.

Two years later the Case Western Reserve team checked the same children and enrolled a new Shaker Heights group in the study.

As reported in the *Journal of the American Medical Association* October 2, 1967, by Drs. Martha L. Lepow, George A. Nankervis, and Robbins, the team found that those who had not received a booster dose, now recommended by the American Academy of Pediatrics, nevertheless had relatively good antibody levels against this disease. The report finds merit in following the Academy recommendation of one booster dose at the time the child enters school, but finds no other boosters are needed for school children — at least in Shaker Heights.

"Probably the most important factor in the maintenance of immunity in any group," the report concludes, "is to reach infants and children who move

---

This article was adapted from information furnished through the University Medical Center, Cleveland.



into the area and who may not have received previous immunization with oral poliovirus vaccine."

The Other Two Studies

In Cleveland's Hough area, this research encompassed a sample of 2,200 children, some of the four- to five-year olds enrolled in the Head Start program. Beginning in 1965 and continuing to 1967, the scientists measured the children's immunity not only to polio but also to tetanus and measles. And, in effect, they also estimate indirectly the children's immunity to two other diseases, because children who are vaccinated against tetanus, as a standard procedure in baby clinics and pediatricians' offices, receive in the same vaccine inoculations against pertussis and diphtheria. This study has not yet been reported.

In Parma, Cleveland's largest suburb, the study now underway is of 1,900 kindergarten children from public and parochial schools — every kindergarten child in Parma for whom parental permission and cooperation could be obtained. Their blood samples, collected in the last two years, are now being analyzed for immunity to measles, the three types of polio, tetanus (whooping cough, diphtheria), German measles, and mumps. It is one of the largest studies of its kind ever attempted.

Some idea of its complexity, and the reason each study takes several years to complete, may be gathered from an explanation of how immunity levels may be measured: First, in thousands of laboratory flasks, the scientists grow large quantities of viruses for each disease. In the Parma study, for example, several viruses including the three different polio strains are under cultivation.

The Level of Hospital Insurance Benefits Are Shown by Study

A recently completed survey has made possible for the first time an evaluation of the levels of hospital insurance benefits for almost 68 million persons covered under insurance company group policies. The segment represents nearly half of all Americans under the age of 65 with some form of private hospital insurance.

The survey was conducted by the Health Insurance Association of America among 56 insurance companies which accounted for 66 per cent of the total group health insurance premiums in the United States in 1966.

Nationally, 149 million persons under 65 were protected against hospital expenses at the start of 1967. Of this number, insurance companies covered about 93 million, including some 68 million protected under group plans.

According to the report, most of those covered under group plans had a broad range of protection.

"About 75 per cent of the persons covered by group health insurance policies have either a com-

bination of a basic policy with a superimposed major medical policy or a comprehensive major medical policy which provides both basic and extended benefits," the report stated.

The study focused on those persons covered by basic group programs (hospital, surgical, medical) which did not have a major medical-type policy.

For these basic plans, the survey showed:

Over 99 per cent of persons had their hospital benefits provided for 31 days or more; nearly 66 per cent had benefits for 70 days or more. (According to U. S. Government statistics, three per cent of hospital stays last beyond 31 days.)

Some 56 per cent had hospital benefits of $18 or more per day, including 18 per cent who had full coverage for the cost of semiprivate hospital accommodations.

Almost 90 per cent had ancillary hospital expense benefits of $200 or more to help pay for hospital "extras" such as laboratory services, x-ray and drugs. About a third of these had such benefits of $1,000 or more.

Seventy per cent of those insured under group surgical plans had maximum surgical benefit schedules of $300 or more.

Eighty per cent of the coverage for nonsurgical medical expense covered doctor visits inhospital only. However, about 66 per cent of the in-force coverage paid for such visits for 31 days or more.

About 66 per cent of persons not covered by compulsory group short-term disability insurance plans had coverage for accidents or illness which did not occur as a result of their occupations. The average amount of weekly benefit payments among the nonoccupational plans was $53.

The survey also noted that comparable levels of coverage were provided to both dependents and employees under the group basic plans examined.

Manual on Alcoholism Available From Chicago Office of AMA

The American Medical Association reports that more than 10,000 copies of the *Manual on Alcoholism,* have been distributed since its release late last October. This 100-page publication, "intended to give physicians a brief outline of the major factors in the causes, diagnosis, and treatment of alcoholism and the medical management of alcoholic patients," is available for 50 cents in the U. S., Possessions, Canada, and Mexico.

Medical students, hospital interns and residents in these areas may obtain it for only 40 cents. The price in all other countries is 60 cents. Requests should be directed to the American Medical Association, 535 North Dearborn, Chicago, Illinois 60610. To facilitate handling, orders should include payment and contain the code number, MH-3.

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Iodide contraindications: tuberculosis, pregnancy.

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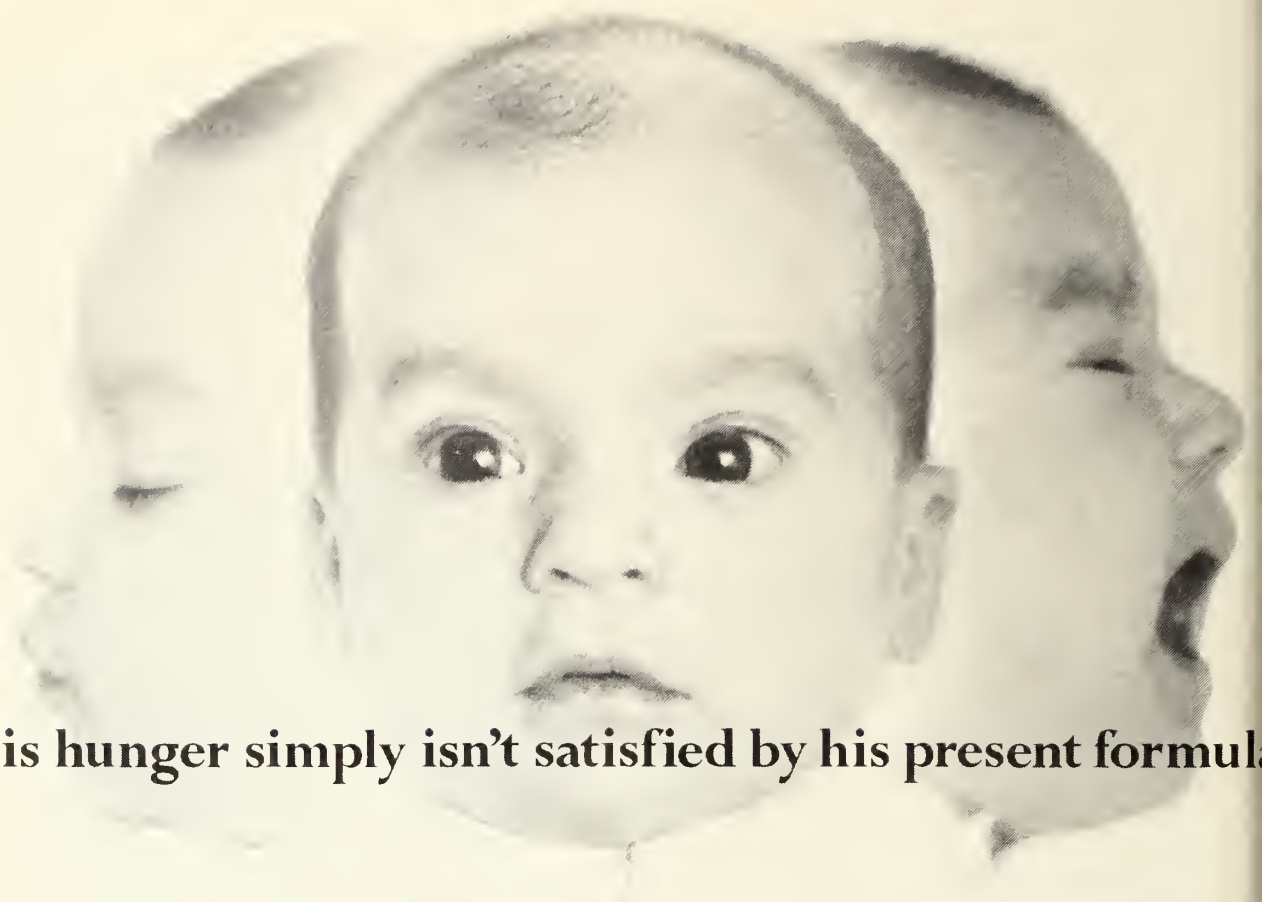
One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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If his hunger simply isn't satisfied by his present formul

the problem could be essential fatty acid imbalance

Excessive appetite, inordinate crying, poor weight gain and skin rashes can be caused by an infant formula that does not have fatty acid balance.[1-5] Linoleic acid is a required nutrient which is converted, in part, to metabolically-active arachidonic acid. Preliminary studies have shown that linolenic acid, if present in sufficient quantity, can adversely affec conversion. Optimil has only amounts of linolenic acid.

Fat analyses of Optimil and two leading modified-milk formulas*

Fatty acids	Optimil % of fat	Prod. #2 % of fat	Prod. #3 % of fat
Saturated	**40.4**	**44.2**	**39.0**
Caprylic	3.3	1.6	2.2
Capric	2.2	1.1	1.5
Lauric	16.0	10.1	11.7
Myristic	6.3	5.1	5.5
Palmitic	10.2	16.2	14.0
Stearic	2.3	9.0	4.5
Unsaturated	**59.6**	**55.8**	**61.0**
Oleic	40.7	33.0	24.7
Linoleic	18.9	19.5	34.6
Linolenic	trace	2.3	1.7

* Mean of three lots tested

imil, an optimum-nutrition infant formula, helps reduce problems

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ns more than enough linoleic
nd only a trace of linolenic.
Optimil-fed infants maintain
ate tissue levels of
donic acid. This is reflected
high caloric efficiency
imil, and helps to satisfy
and promote efficient
gain and a clear complexion
es an infant contented.[6-8]

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m-nutrition infant formula.
in the new full 16-fluid
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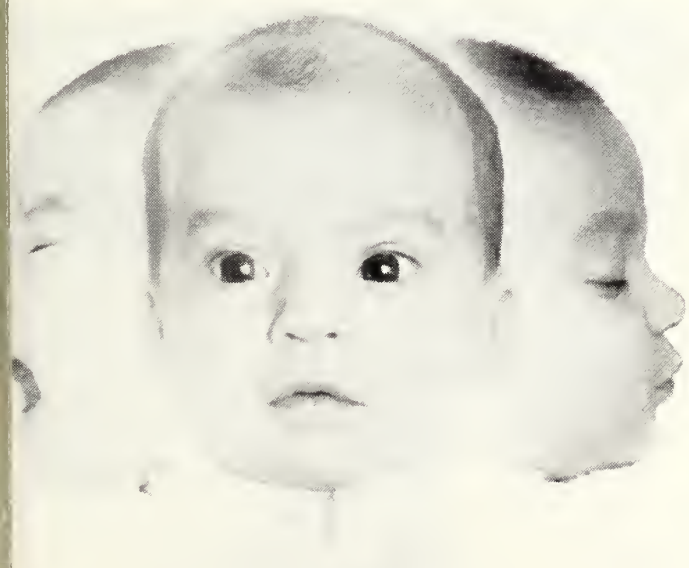
in digestibility

Of all the fatty acids commonly found in infant formulas, stearic acid is the least digestible.[9] Optimil contains a comparatively low level of stearic acid and a relatively high level of oleic acid, which has been shown to aid in the absorption of stearic acid. Optimil also has a high ratio of unsaturated fat to saturated fat which further enhances the formula's digestibility.

1. Hansen, A. E., et al: Pediatrics 31:171, 1963. 2. Holman, R. T.: Fed Proc. 23:1062, 1964. 3. Holman, R. T., et al.: Amer. J. Clin. Nutrition 14:70, 1964. 4. Hepner, R., et al.: Pediatrics 33:94, 1964. 5. Pikaar, N.A., and Fernandes, J.: Amer. J. Clin. Nutrition 19:194, 1966. 6. Hepner, R.: Current Therapeut. Research 9:140 (Suppl. 35) 1967. 7. Hart, L. M.: Ibid., p. 179. 8. Nichols, M. M.: Ibid., p. 184. 9. Young, R. J. and Garrett, R. L.: J. Nutrition 81:321, 1963.

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Stooling problems and perianal dermatitis are minimized by the presence of lactose. A low renal solute load assures ample expendable water reserves to meet stress situations. Adequate amounts of all-known essential vitamins and 8 mg. of iron are included per diluted quart.





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when he just can't sleep

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One-Half Sodium Amobarbital and
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supplied in ¾, 1½, and 3-grain Pulvules



ıal helps wakeful patients fall asleep fast, stay lep all night.

cations: Tuinal is indicated for prompt and moder-ɛ long-acting hypnosis. It is not suitable for con-ıous daytime sedation.

traindications: Barbiturates should not be adminis-d to anyone with a history of porphyria, nor should be given in the presence of uncontrolled pain, be-e excitement may result.

ning: May be habit-forming.

autions: Tuinal should be used cautiously in pa-s with decreased liver function, since prolongation ffect may occur.

erse Reactions: Idiosyncrasy, such as excitement, ıgover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during the months indicated. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

DECEMBER

Allen
Thomas T. Weis, Lima

JANUARY

Ashtabula
William P. Perednia, Conneaut

Butler
G. Habib Nackhla, Hamilton
Ink-Khoen Sih, Hamilton

Darke
Antonio R. Alba, Ansonia
Thomas P. Chase, Ansonia

Greene
Erol Bastug, Xenia
Max E. Blue, Jr., Xenia

Hamilton
James L. Armitage, Cincinnati
Charles O. Dillard, Cincinnati
Manfred E. Krause, Cincinnati
David S. Schwab, Cincinnati
Roslyn Seligman, Cincinnati
Margery R. Sper, Cincinnati
Charles W. True, Cincinnati
Thomas R. Werner, Cincinnati

Lake
Dale C. Havre, Willoughby
Catherine C. Jarchow, Cleveland

Muskingum
John W. Ray, Zanesville

Perry
Alfredo G. Cruz, New Lexington

Richland
Amin A. Baddour, Mansfield
Donald N. Beddard, Mansfield
James F. Clements, Mansfield
Gerardo L. Yubero, Mansfield

Scioto
William B. Miller, Portsmouth

Summit
Joseph Bastolla, Akron
Abu A. Faruque, Akron
Augusto D. Castro, Akron
Robert F. Matzke, Akron

Wayne
Craig W. Campbell, Wooster

Wood
Restituto H. Alonzo, Bowling Green
Donald Merz, Bowling Green

Wyandot
Nasser Zohoury, Upper Sandusky

"Horizons Unlimited" Now in Film Form For Showing to Career Seekers

Introduced less than two years after its paperback counterpart, "Horizons Unlimited," the AMA's recent film contribution in the expanding area of health careers, is now available for booking. Created to familiarize young adults with the wide range of rewarding career opportunities in medicine and allied fields and emphasize the ever-increasing need for trained health personnel, it is provided complimentarily except for return postage.

This 16 mm, sound-color production replaces the now-obsolete film, "Helping Hands for Julie." It features approximately 12 specific health career fields and is about 28 minutes in length. School and nonmedical groups may secure a print from Modern Talking Pictures, Inc., Prudential Plaza, Chicago, Illinois 60601. Physicians and auxiliary members should contact the AMA Medical Film Section, 535 North Dearborn, Chicago 60610.

In Obesity,
anorectic action
with fewer unwanted
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Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

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he can't eat bulk foods

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for easy overnight relief of constipation that comes from the therapy and restricted diet of the peptic ulcer patient. Modane works in the lower bowel to stimulate peristalsis that is so often inhibited by anticholinergics and to counteract the tendency of many antacids toward fecal impaction. Modane gives gentle, easy evacuation and encourages regularity.

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Encourages regularity.

COMPOSITION AND DOSAGE: MODANE Tablets (Yellow)...each contains 75 mg. danthron, 25 mg. d-calcium pantothenate...1 tablet with the evening meal, or as required by patient.

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MODANE Liquid...each teaspoonful (5 cc) contains 37.5 mg. danthron, 12.5 mg. d-calcium pantothenate...Adults—1 to 2 teaspoonfuls with the evening meal. Children 12 years—¾ to 1½ tsp.; 6 years—½ to 1 tsp.; 3 years—⅓ to ⅔ tsp.; Infants 1 year—¼ tsp.; 6 months—⅕ tsp. (20 drops)—or as required by patient.

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Construction Progressing on Basic Science Building at OSU

Construction work was resumed in January on the Medical Basic Science Building at Ohio State University after being held up for months while questions of equal employment opportunities were ironed out. The project — largest in the current building program — is at the south edge of the OSU campus in the Medical Center area. (Refer to March, 1967 issue of *The Journal*, page 352 for the architect's sketch of the building.)

Following is a description of this new facility and a discussion of its place in the medical education program adapted from information provided by the university.

The building was planned around an instructional program that integrates subject matter of the six basic medical sciences and consolidates their requirements for facilities, staff, and equipment.

When the need for new basic science facilities became obvious a few years ago, the medical faculty set about on some serious discussions. Some of the problems faced were: how to expand enrollment to 200 entering medical students a year from the present 150 to help meet the need for doctors; how to improve their training; and how to do all this within reasonable cost.

It became clear that to duplicate all required facilities for each of the six basic science departments would necessitate a structure or complex of structures costing an estimated $60 million. The building now under way will cost some $12 million, with financing split about 50-50 between a federal grant and state bond issue money.

As the faculty discussed what direction instruction should go, the majority opinion leaned toward an integrated, or interdisciplinary approach — a break with tradition.

The old system inherited primarily from Europe involved departments — pharmacology, anatomy, physiology, physiological chemistry, microbiology, and pathology — each with its own lecture halls, laboratories, and equipment. In his clinical years, the student integrated what knowledge he needed from each discipline.

The Ohio State faculty decided to adopt the newer concepts of teaching. Faculty members felt that they could best help the beginning medical student by presenting multidiscipline learning experiences in the basic sciences, thus enabling him to

(Continued on Page 315)

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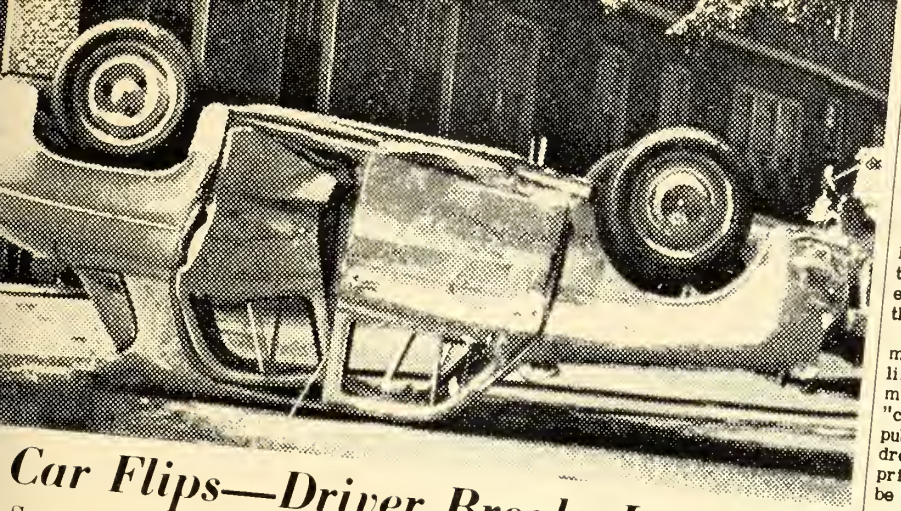
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Sept. 7. John P. Jones of ... incurred a broken leg today ... driving ... Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its ... Hasn't he ... it ...

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He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic 1/4 grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

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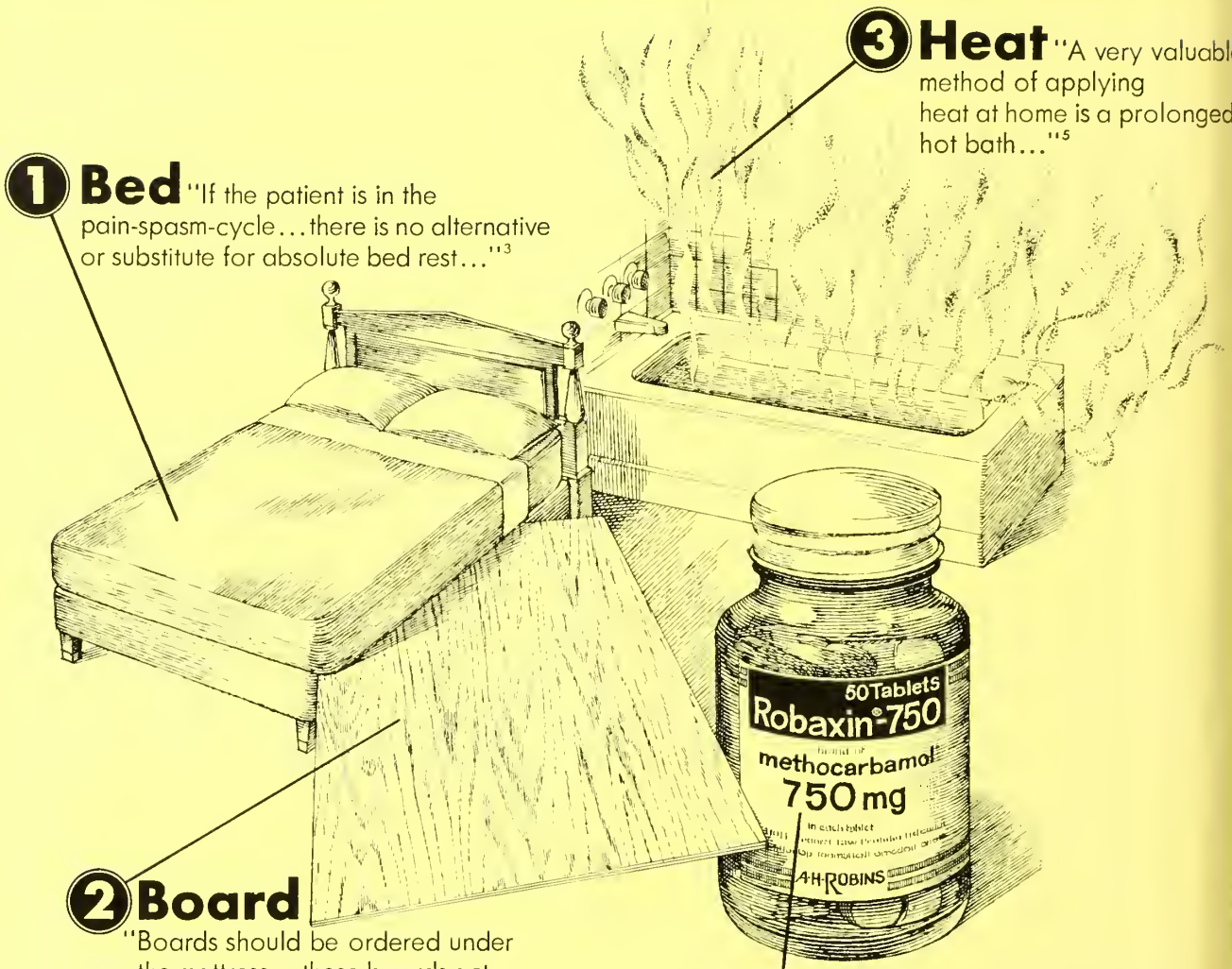
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LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Roboxin® Tablets (methocarbamol, 500 mg.) Roboxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. *8*:950, 1966. (2). Gottscholk, L.A.: GP *33*:91, 1966. (3). Rowe, M.L.: J. Occup. Med. *2*:219, 1960. (4). Cozen, L.: South Dokoto J. Med. *18*:26, 1965. (5). Soto-Holl, R.: Med. Sc. *14*:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. *62*:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. *62*:1985, 1962.

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utilize this coordinated knowledge in his work with patients which now begins during his first year.

The new building in the Medical Center, between West Ninth and West Tenth Avenues, will facilitate this multidiscipline approach. It will bring the six departments under one roof in a model of simplicity and compactness, without unnecessary duplication.

It will accommodate an instructional program taken to the students individually, in small groups, or in larger groups, and team teaching as well as the individual kind.

The first floor will have accommodation for 200 first-year students, the second floor providing the same space for second-year students. Each floor is planned in modules with one complex of four self-contained units housing 16 students each and a second and third complex with three units of 16 each and one unit of 20 students.

Something different can go on in each unit at any given time. Instructors can move in and out of units. At times, one instructor or a team might assemble two or more units for special instruction.

On the third floor will be facilities for anatomical dissection. Advanced students and post-M. D.'s will carry on special projects and elective work there also.

The fourth and fifth floors will house offices of the six departments, providing each with a seminar room. Supply and central glassware washing areas are planned for the basement.

For the first time, the student will not have to wash his own laboratory ware, and his chemicals will be prepared and ready for him in proper mixtures.

In the administrative wing of three floors, to be connected at the ground, or basement level, and first and second floors with the main science building, will be two large lecture rooms capable of handling 275 students each. Equipped with all the modern teaching aids, these will be located on the ground and first floors.

The second floor will house the College of Medicine administrative offices.

Completion of the building is expected in 18 to 24 months.

Neuromuscular Diseases of Children To Be Cook County Subject

The Cook County Graduate School of Medicine announces a two-week intensive continuing education course in The Neuromuscular Diseases of Children with Special Emphasis on Management, to be given by Dr. Meyer A. Perlstein for the period of June 3-14, 1968.

For further information, write to the Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612.



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Scientific Section

VOL. 64 MARCH, 1968 NO. 3

The Single Thyroid Nodule

A Method for the Assessment of Its Functional Characteristics

JACK MARKS, M.D.

IN THE clinical evaluation of the patient with a single thyroid nodule, radioactive iodine scintiscanning has assumed an important role because of the high incidence of carcinoma associated with the nonfunctional or "cold" nodule. Meadows,[1] in a study of 122 patients with single thyroid nodules, found that 103 patients were clinically not toxic. Of these, he described an incidence of carcinoma in 55 per cent of those patients with nonfunctional nodules, ie, nodules that did not concentrate radioactive iodine. Of the nodules classed as functional, ie, concentrating radioactive iodine to the same degree as the normal adjacent thyroid, the incidence of carinoma was seven per cent, in the hypofunctional group six per cent, and in the hyperfunctional group four per cent. Nineteen patients with a single nodule were clinically thyrotoxic. Only one carcinoma was found in this group. With some variation, these figures have been validated in numerous reports and serve to draw attention to the high incidence of thyroid cancer in patients having "cold" or nonfunctional thyroid nodules.

The availability of rectilinear scanners or other radio-nuclide imaging devices varies widely from community to community. It is the purpose of this communication to describe a relatively simple method for determining the functional characteristics of single nodules of the thyroid. We cannot represent the method as a definitive technic, but we believe it might serve to delineate those patients requiring additional study from those who might be safely managed by conservative methods and continued observation.

The method requires only a scaler, a scintillation detector with flat field collimator, and preferably a spectrometer, but the latter is not critical.

The basic method is that described by Brucer[2] which sets forth the geometry for thyroid counting as 10 inches from neck to scintillation detector crystal and suggests the use of a flat field collimator of 3 inch length, flared from 2 inches at the crystal to 3 inches at its end and the use of a so-called "A" filter of 1/16 inch lead to cover the crystal and a "B" filter, measuring 4 by 4 by ½ inch, which

The Author

● **Dr. Marks, Columbus, is Instructor, Clinical Medicine, The Ohio State University College of Medicine; Chief of Medicine at St. Ann's Hospital, and a member of the Active Staffs of Grant Hospital and St. Anthony Hospital.**

Submitted June 13, 1967.

covers the thyroid field when background is being determined.

Figure 1 demonstrates the basic counting system as proposed by Brucer.[2]

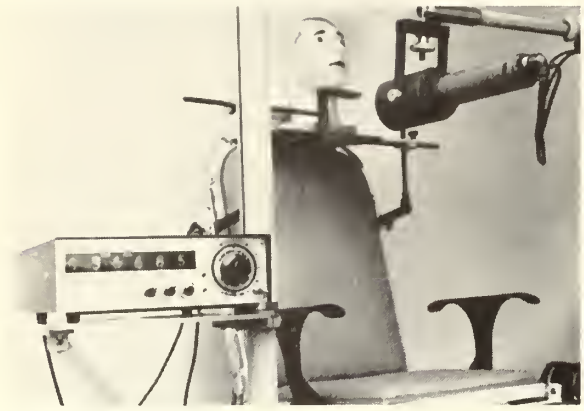


FIG. 1. *Arrangement of Equipment for the Thyroid Uptake Test. The "C" brace under the phantom's chin supports the lead filters as shown in Fig. 2.*

If "B" filters are prepared with cutouts of 1 inch by 1 inch in various locations, (Fig. 2) then in 16 periods of counting the entire 16 inches which comprise the area of the "B" filter can be counted separately and in this fashion the area occupied by a nodule compared with other areas occupied by normal thyroid tissue.

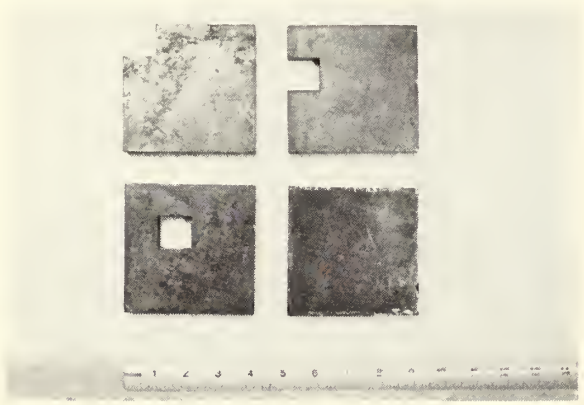


FIG. 2. *The filters with cutouts are turned successively until the 16 sq. in. of filter area have been counted separately. The filter in the right lower corner is employed to count background.*

Figure 2 demonstrates a series of "B" filters, each with a 1 inch by 1 inch cutout. When the various filters are turned in the holder, placed before the patient's neck, the 16 sq. in. that comprise the "B" filter area can be individually counted. The right lower "B" filter is without cutout and is employed in a standard uptake test.

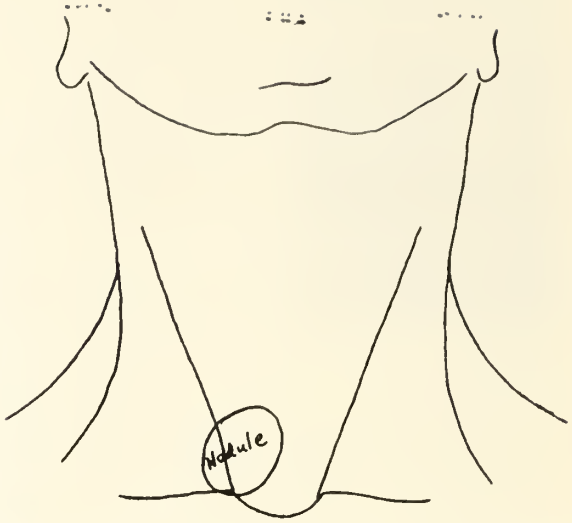


FIG. 3. *Case 1. The anatomic location of the thyroid nodule is portrayed.*



FIG. 4. *Case 1. The initial scintiscan does not show 131-iodine concentration in the area occupied by the thyroid nodule.*

Case Reports

Case 1. The patient was a 35 year old woman whom I saw initially on April 21, 1965. Physical examination revealed an unsuspected nodule at the inferior pole of the right lobe of the thyroid gland. A 24-hour I^{131} uptake on April 22, 1965 was 16.2 per cent. Figure 3 portrays the site of the thyroid

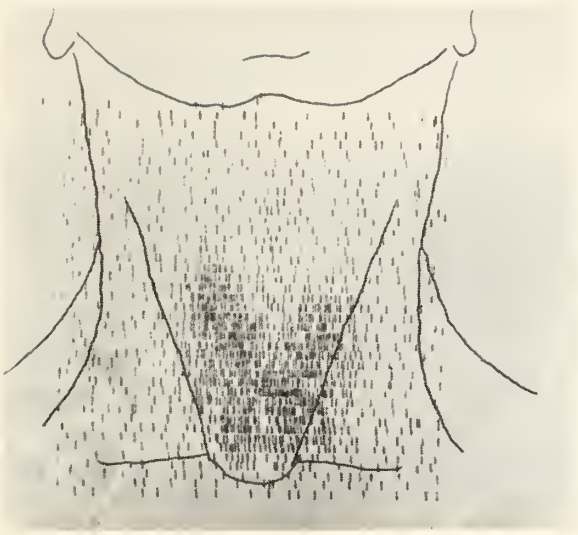


FIG. 5. *Case 1. The Suppression Scan does not reveal any areas of increased uptake. The nodule does not concentrate 131-iodine.*



FIG. 6. *Case 1. Post Thyroid Stimulating Hormone Scan. The thyroid nodule does not concentrate 131-iodine. A pyramidal lobe, however, is demonstrated.*

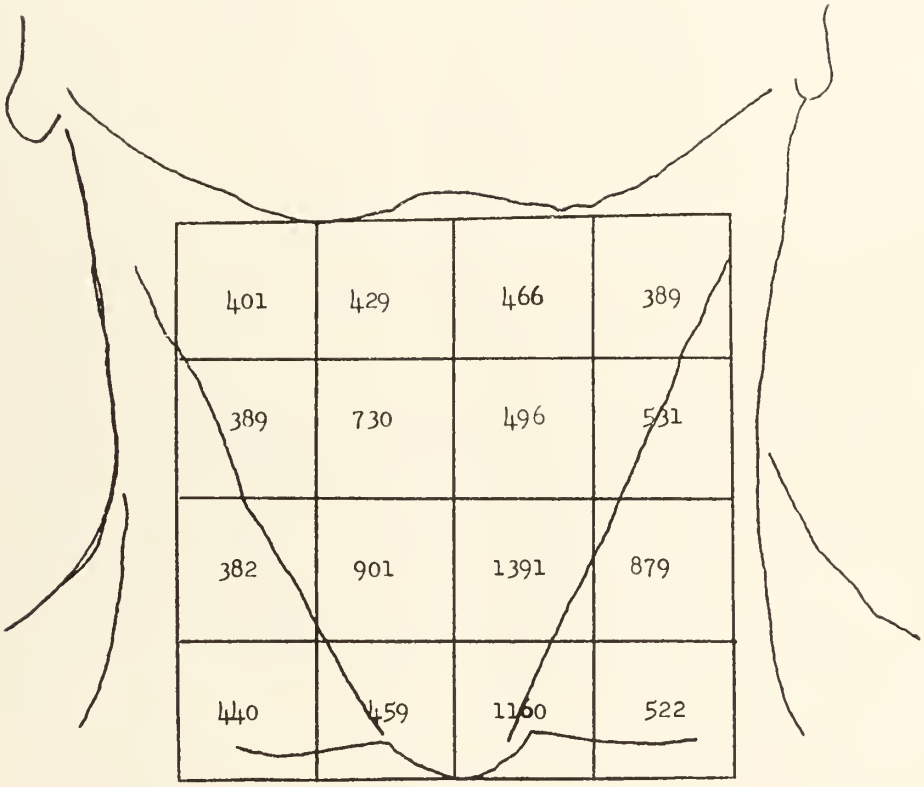


FIG. 7. *Case 1. The area occupied by the nodule (Square 459) scarcely exceeds the background count of 399 counts per minute. The corresponding area of the left lobe of thyroid (Square 1160) concentrates 131-iodine in greater amount.*

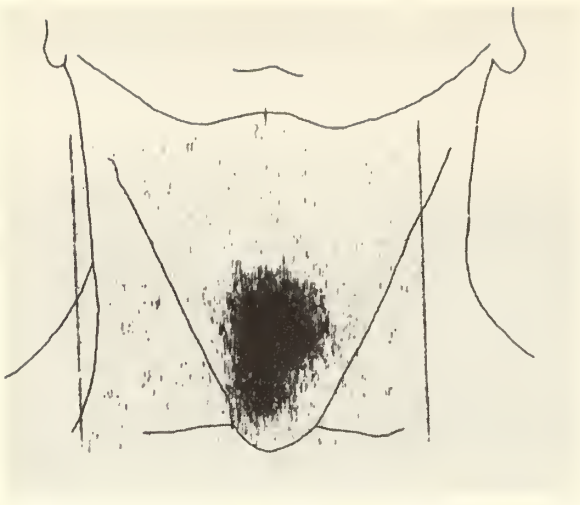


FIG. 8. *Case 2. The patient's "nodule" concentrates the great preponderance of radioactivity in the thyroid region.*

nodule. The scintiscan obtained at that time is shown in Figure 4.

In order to suppress the functioning thyroid tissue, the patient was given levothyroxine 0.3 mg. daily for three weeks.

On May 14, 1965, following a second tracer dose of iodine-131, a scan was repeated which showed some suppression of activity as compared with the prior scan. The nodule did not visualize. (Fig. 5).

The patient received 10 units of a thyroid stimulating hormone on May 17 and 18 respectively, and on May 19, following a third tracer dose of iodine, a post stimulation scan was made. (Fig. 6).

This scan again fails to delineate any radioactivity in the thyroid nodule, but does demonstrate a pyramidal lobe. Following this scan, the patient had her thyroid field counted in 16 separate one-minute counts. Figure 7 shows the counts obtained at each field.

Background (with the complete "B" filter in place) was 399 counts in one minute. The data shown represent gross counts, ie, background is not subtracted. It can be seen that the square occupied by the nodule (designated 459) has counts barely above background while the adjacent square (designated 1160), which occupies the area of the inferior pole of the left lobe of the thyroid, concentrates radioactive iodine in greater concentration.

With the foregoing evidence that this was indeed a "cold" or nonfunctional nodule, the patient was subjected to exploratory surgery on May 28, 1965. The nodule was resected and the pathologist's report was that of "nodular colloid goitre" without evidence of malignancy. Meadows' data,[1] relating to "cold nodules with polar replacement," of which this is an example, showed an incidence of malignancy of 73.3 per cent.

Case 2. The second patient whose thyroid con-

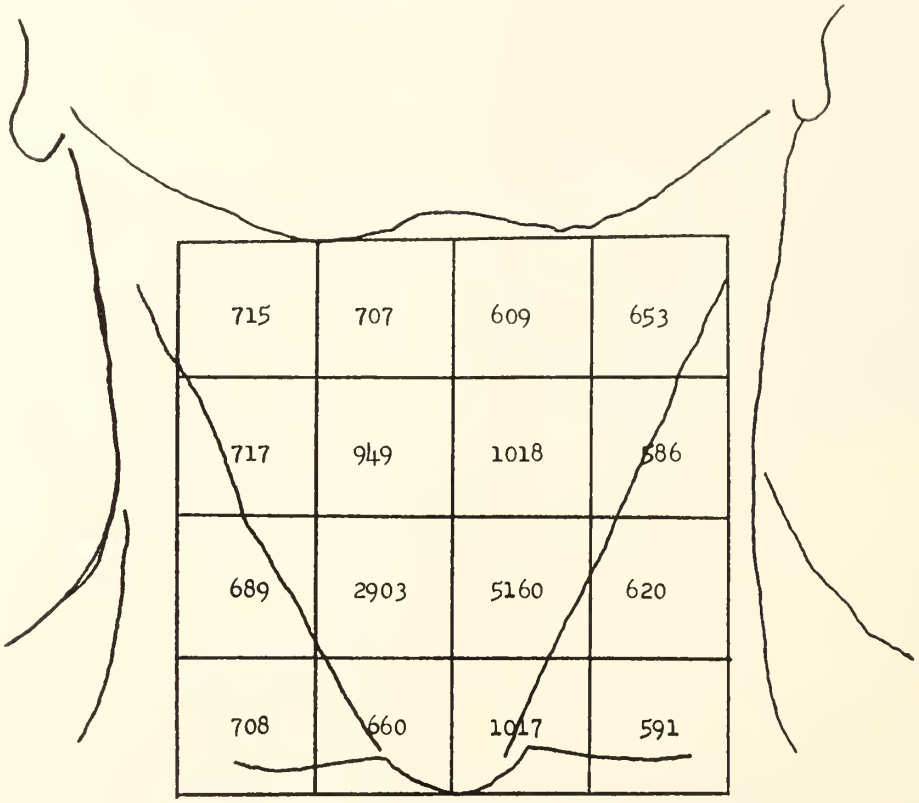


FIG. 9. *Case 2. The area occupied by the "nodule," (Square 5160) is shown to correspond to the "nodule" noted in the scintiscan of the patient's thyroid gland.*

dition serves to illustrate this method was a 39 year old woman whom I saw April 28, 1967. The patient had had a subtotal thyroidectomy at age 13 for symptoms of hyperthyroidism, and at age 15 she had a second subtotal resection for recurrence of toxic symptoms.

On physical examination she showed mildly myxedematous facies and a nodule was noted at the left of midline about one inch above the suprasternal notch. Her hemoglobin level was 11.0 gm./100 cc. and hematocrit was 33.0 per cent. A protein bound iodine determination was 4.1 mcg./100 ml. A T^3 Test was 27.0 per cent. (Normal is 28 to 35 per cent.) The half relaxation time of the Achilles tendon jerk was measured at 360 msec. in the overlap region of both euthyroid and hypothyroid populations. The 24-hour I^{131} uptake was 26.5 per cent, a normal value.

A scan of her thyroid gland was made (Fig. 8) and revealed that the "nodule" in question was essentially all of the patient's remaining thyroid tissue.

Background counts with full "B" filter was 715. A field count without subtraction of background counts is shown in Figure 9 and revealed that the squares, other than those occupied by the nodule, had nearly background count values, while that area occupied by the nodule, designated 5160, held the great preponderance of the radioactivity. The squares adjacent to 5160 also show some increased counts.

These studies suggest that the patient's thyroid remnant had achieved some enhanced capacity to trap iodine, as indicated by a 24-hour uptake value of 26.5 per cent, but was incapable of maintaining the patient's physiologic needs as manifested by low PBI and T_3 values, as well as her clinical appearance. Increasing doses of levothyroxine to a final schedule of 0.3 mg. daily were prescribed.

Comment

By this method of counting the neck region sequentially, one square inch at a time, if the counts obtained at the location of the thyroid nodule are compared with normal thyroid, then the nodule's functional characteristics can be judged. This method would have limited application in the study of the multinodular gland.

The method described is not represented as an improvement over scintiscanning with conventional rectilinear scanners or imaging devices, but rather as a simple and useful method for assessing nodule function when more elaborate isotope facilities are not readily available.

References

1. Meadows, P.: "Thyroid Nodules, Progress in Medical Radioisotope Scanning." *Proceedings of a Symposium*, U. S. Atomic Energy Commission, ORINS, Oct. 22-26, 1962, pp 296-311.

2. Brucer, M.: *Thyroid Radioiodine Uptake Measurement, A Standard System for Universal Intercalibration*. U. S. Atomic Energy Commission, (June) 1959.

HYPOTHYROIDISM is associated with an increase in plasminogen, a decrease in an inhibitor of plasminogen activation, and a possible increase in plasminogen activator, whereas hyperthyroid patients show opposite changes in fibrinolytic enzyme system. These changes may play some part in the association between treated hypothyroidism and occlusive coronary disease. More fundamentally they suggested that the thyroid has a regulating influence on fibrinolysis. — D. A. Turner, M. SC., T. K. Audhya, B. SC., D. G. Cramp, A. I. M. L. T., C. D. Holdsworth, M. D., M. R. C. P., and Neil McIntyre, M. B., B. SC., M. R. C. P., London: *British Medical Journal*, 4:148, October 21, 1967.

Heart Page

Peripheral Vascular Disease

IV. The Limitations of and Indications for Surgical Treatment Of Chronic Occlusive Arterial Disease

RAY W. GIFFORD, Jr., M.D.

THERE ARE two important indications for surgical treatment of chronic occlusive arterial disease: (1) incapacitating intermittent claudication, and (2) severely ischemic limbs that might otherwise have to be amputated because of painful neuropathy or ulcers that will not heal.

When intermittent claudication is the only symptom of atherosclerosis obliterans, the occlusive lesions are usually segmental and affect the larger arteries so that endarterectomy and/or bypass grafting is feasible technically. But intermittent claudication is seldom so incapacitating that it interferes with gainful employment, and it usually does not become progressively worse. Consequently, most patients learn to adjust to the disability and will not choose operation unless or until the survival of the limb is threatened by ischemia. Fortunately, this occurs in less than 10 per cent of nondiabetic patients, but unfortunately, when it does occur, the disease is usually so far advanced that it is impossible successfully to bypass the occluded areas because disease in the tibial arteries impedes runoff and predisposes to thrombosis in a graft. Nevertheless, except in severely ill patients, amputation should not be performed until appropriate angiography has demonstrated that revascularization is impossible, unless the limb is hopelessly gangrenous.

Endarterectomy and/or bypass grafting does not prevent the development of atherosclerotic lesions either proximally or distally to the site of operation. Hence it is not possible to prevent worsening of the ischemia from proximal or distal extension of the disease by an operation performed while the occlusive disease is still technically amenable to current methods of revascularization.

Few patients with thromboangiitis obliterans are suitable subjects for revascularization, because the occlusive lesions of this disease characteristically occur in the tibial arteries where endarterectomy and bypass operations are not possible.

Patients with peripheral atherosclerosis obliterans frequently have occlusive disease in the cerebral and/or coronary arteries as well, and for this reason they are less-than-ideal operative risks and have a compromised life expectancy. Most patients with atherosclerotic occlusive arterial disease of the extremities die of the complications of coronary or cerebral vascular insufficiency. Very few die as a direct result of the arterial disease in the extremities. Revascularization of a limb is, therefore, not a life-saving procedure. It is imprudent to subject a patient with symptomatic coronary disease to the risk of an operation to revascularize the lower extremities solely to relieve intermittent claudication, when his activities and longevity are already limited by angina pectoris.

The mortality rate (from two to ten per cent) for bypass procedures in the aortoiliac region is fairly formidable for a condition that is not life-threatening. While the mortality rate is negligible for operations to bypass occlusive lesions in the superficial femoral artery, the high incidence of subsequent thrombosis of these grafts and the threat of prolonged convalescence from infection around synthetic prostheses have been a deterrent to their use. More hopeful results have been achieved by using autogenous veins to bypass lesions in the femoropopliteal area.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio.

Ecological Characteristics of Clinical Tetanus

DOMINGO D. J. LEONIDA, M.D., M.P.H.

ALL LIVING THINGS are affected by other living and nonliving entities of the environment. As physicians we are going to recognize the increasingly salient ecological factors that characterize the biosphere. The future holds the promise of identifying these factors that hitherto defied definition. Their characterization in the natural history of a disease gains added impetus as medicine strives to foster those exchanges among the biological, physical and social sciences which have brought us to the threshold of still newer and broader horizons.

Man's first experience with disease was irrevocably bound to his need for survival. His progress depended upon his ability to control or influence the natural entities that shared his environment.

One of the most serious health problems in our enlightened age is the indifference toward prevention of disease. Unless we experience epidemics of a disease, we almost routinely postpone or delay preventive measures for such a disease because of the fantastically low priority we ordinarily give to prevention. Tetanus immunization is not an exception.

The fact that tetanus still occurs serves as a warning that the ecological and host-related biological factors essential for the transmission of this disease still exist. Consequently, it is important to look at this disease in order to determine whether salient features of its ecology might be uncovered and described further.

Tetanus is caused by bacteria *(Clostridium tetani)* through production of a very potent neurotoxin that compromises the normal function of specific components of the nervous system.

Each year, from three hundred to five hundred persons in the United States, ranging from neonates to adults over 50 years of age, are reported as having tetanus,[1] and 60 per cent of them die. Although mortality decreased sharply for many years, starting as early as 1918,[2] the case fatality rate remains high. In this article, 99 cases of reported clinical tetanus were studied to determine some ecologic-epidemiologic features of this disease reported in a given geographic area from 1959 to 1964.

The Author

● Dr. Leonida, Albany, New York, former Epidemiologist, Ohio Department of Health, is currently Medical Director, Immunization Activities, Bureau of Epidemiology, New York State Health Department.

Methods and Procedures

In order to gather uniform information, a questionnaire was designed to obtain the data used in this article (Fig. 1). Copies of the questionnaire were distributed to all representatives of the Communicable Disease Division of the Ohio Department of Health who personally interviewed each patient reported as having had clinical tetanus. Information for this planned survey was obtained from a parent or the nearest of kin where the patient was not available, from the attending physician, and from the diagnostic laboratories of hospitals. All clinical cases reported from 1959 through 1964 were interviewed except for three cases in which the diagnosis of tetanus was in doubt. The latter were not included in the survey involving 99 cases. Criteria for diagnosis of tetanus were based upon clinical symptoms and signs with or without confirming laboratory studies.[3]

The age specific morbidity and mortality rates were determined in terms of the number of tetanus

Submitted June 19, 1967.

Fig. 1. Questionnaire Designed for Obtaining Data Used in This Article

TETANUS INVESTIGATION

Name: .....

Address: City ..... County .....

Employer: .....

Past Military Service: date and branch of service .....

.....

Clinical Data:

Name of doctor consulted for treatment: .....

.....

Address of Above Physician: .....

Diagnosis Made by Physician at First Visit: .....

.....

Date of Hospital Admission: .....

Name of Hospital: .....

Address of Hospital: .....

Is Hospital in same County as Patient's Residence: .....

Date of Hospital Discharge: .....

History of Present Illness (from hospital chart if available): .....

.....

.....

.....

Summary of Physical Examination: .....

.....

.....

Diagnosis After Hospital Admission: .....

.....

.....

.....

.....

.....

cases reported within an age segment of the population and the total number of people at risk within that age segment (per 100,000) in Ohio.

Results

1. The Role of Environment and or Occupation

Most of the tetanus cases were distributed in predominantly rural farm communities accounting for 83 of the cases. Fifty-nine cases occurred among farmers in rural farm communities and 24 cases were nonfarmers by occupation but the lesion suspected as the portal of entry for *Clostridium tetani* occurred in a rural farm environment. Although most cases of reported tetanus have occurred in predominantly rural farm areas, eight cases occurred in rural nonfarm areas. The urban communities were not exempt from this problem; eight cases came from metropolitan centers.

2. Morbidity by Age

From Figure 2, it appears that the 45 to 54 years age group is the population segment selected for the highest risk of reported clinical tetanus, since it has the highest age specific morbidity rate. The lowest age specific morbidity rate occurred in the 20 to 44 years age group. Such a rate might readily be ascribed to the well-immunized veterans of World War II and the Korean Emergency, immunization by family doctors, and the improving public health clinical services available to everyone when this group was born and attended the primary and secondary schools. In the population under 44 years of age, the group four years old and under experienced the highest morbidity rate that came close to simulating the rate of those 55 years old and over — the group that did not have the benefit of mass tetanus immunization comparable to those in recent military services.

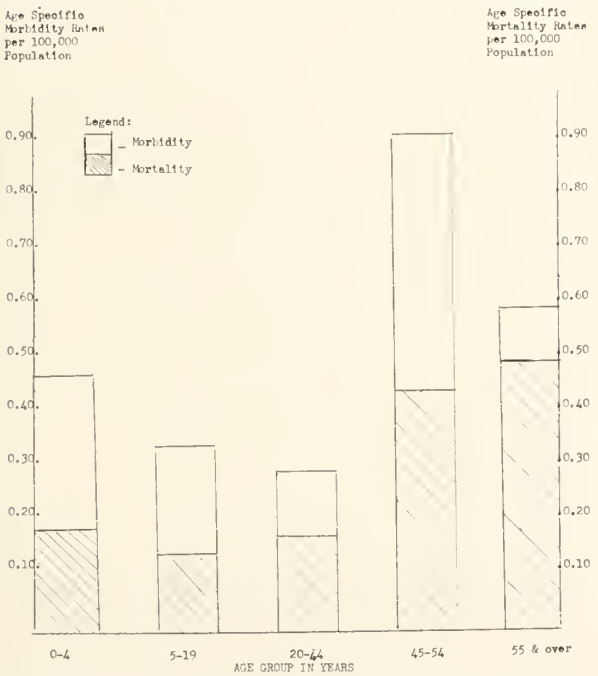


FIG. 2. *The relationship of tetanus morbidity and mortality to age groups (1959-1964).*

3. Age and Sex as Related to Morbidity

Age-sex specific morbidity rate was highest among males 55 years old and older. The lowest rate occurred in five to ten year old females.

4. The Influence of Age on Mortality

The highest mortality rate was experienced by the 55 years and over group. (There were only two individuals listed over 65 years of age. For convenience of presentation, they were included within the nearest cohort.) The lowest mortality rate occurred in the 5 to 19 years group.

5. The Role of Tetanus Antitoxin (Equine)

Tetanus (equine) antitoxin was administered in varying amounts (ranging from 110 units to 1,165,000 units) and in different parenteral routes (intramuscular and intravenous) in 82 per cent of the cases reported. No relationship was found between the quantity of antitoxin given and the route of administration on one hand, and the probability of recovery from this disease on the other. Data were not available on whether tetanus antitoxin was administered to 18 per cent of the 99 cases reported. Among eight nonfatal cases and ten fatal cases of tetanus, antitoxin was given within the first 24 hours after onset of symptoms. After the first 48 hours following onset of symptoms antitoxin was given to eight nonfatal and eight fatal cases. The danger associated with the use of equine tetanus antitoxin is well known.[4]

6. Seasonal Influence

Figure 3 shows the seasonal distribution of 99 reported tetanus cases. Most of the cases occurred during (the latter two-thirds of the calendar year) late spring, summer, and autumn. A few cases were noted in winter and early spring. The peak is realized in May and again in August.

7. Site of Lesion — the Probable Portal of Entry

Fifty-nine per cent of all reported cases of tetanus (both fatal and nonfatal cases) from 1959 to 1964 involved wounds of the lower limb; 15 per cent of all 99 cases had wounds of an upper limb; 13 per cent had wounds of the face, head, or oral cavity; and 5 per cent had wounds of the trunk. The majority of these wounds were trivial in nature. No suspected portal of entry was found in 8 per cent of tetanus cases reported during this same period (See Fig. 4). Generally, severity of injuries did

not seem to influence the results of the superimposed clinical tetanus.

8. Age Characteristics of Reported Tetanus Cases

The mean age of the 99 reported tetanus cases was 37 years. There were just as many people with tetanus over and under 42 years of age (median). The most frequently recurring age mentioned was 13 years. The ages of the 99 cases of tetanus ranged from one week to 94 years of age. These reported cases of tetanus occurred almost exclusively among people without active tetanus immunization. Only two cases were known to have had some kind of previous tetanus toxiod inoculation; these two cases recovered from the disease.

Discussion

Since the case fatality rate was highest in the individuals 55 years and older, one can ponder the possibilities accounting for this phenomenon: such as the availability of tetanus toxiod during the '30's[5] when these individuals were young adults; the lack of mass immunization in this country comparable to the large population group immunized against tetanus and other diseases during World War II and the Korean Emergency. Immunizations by family physicians and the improving public health clinical services available to everyone when this group was born, and attended elementary and secondary schools was a far cry from that known today.

In contrast, one also considers the probable roles of preschool and school immunization, health education, however inconsistent or varied they might be from school to school, from city to city, county to county, and the rather generally illdefined constitutional factors that could contribute to the lowest morbidity and case fatality rates in the school age group (5 to 19 years of age).

Since fatalities in the zero to four years of age group were confined to those who were not immunized, and since this group experienced the highest tetanus morbidity rate among people under 44 years of age, the indication for active tetanus immunization among children under five years of age is not only clear but imperative. Private medicine and public health have the basis for a definite mandate in serving this group of children.

Tetanus morbidity rate of children from birth through four years of age came close to simulating the rate of people who did not have the benefit of mass tetanus immunization as was common among military personnel during World War II and the Korean Emergency. Better and earlier tetanus immunization is needed by this group of children. No rationale exists for delaying tetanus immunization among susceptible children.

Occupational groups at greatest risk of tetanus are farmers and people who work in approximately the same general type of environment. Although worldwide in occurrence, tetanus does occur as a disease among farmers in the United States. The working conditions of such groups probably exert a significant role since contamination of wounds with manured soil can easily occur in this milieu.

The age-race specific morbidity rates were consistently higher among nonwhites in each age group. These differences, however marked, could easily be explained by the glaringly disproportionate sample sizes of the two populations within the survey.

The improving immunization status and the developing school health educational programs might account for the lowest mortality rate in youngsters

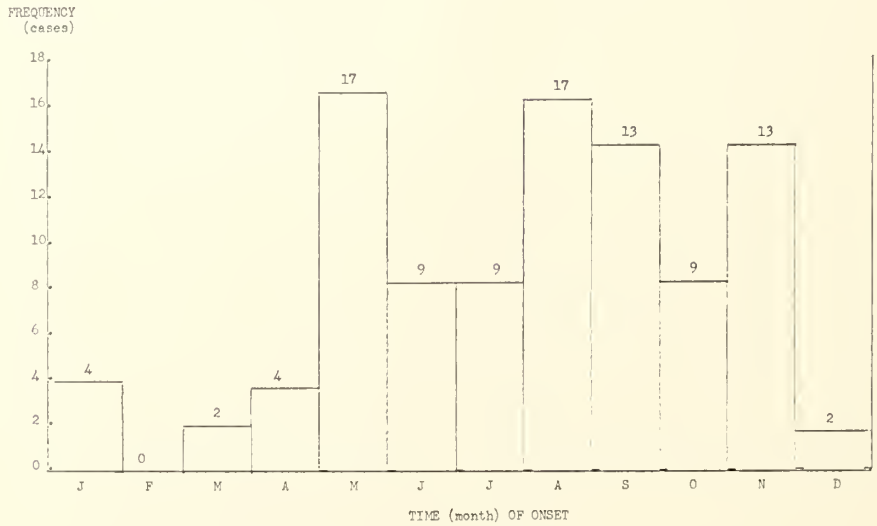


FIG. 3. *The distribution of 99 reported tetanus cases according to month of onset (1959-1964).*

from 5 to 19 years of age. Legislation (effective 1959), requiring immunization against tetanus and other diseases for children prior to school admission did not seem to change considerably the morbidity and mortality rates experienced by this population during the years (1959-1964) covered by this survey.

The mortality rate of the group four years old and under was not the lowest among the population segments under 44 years of age. The fatalities in this particular segment of the population occurred exclusively among unimmunized children. A definite need for early preschool active tetanus immunization is indicated.

The higher incidence of tetanus during the warmer months of the year seems to be associated with increased out-of-doors recreational and occupational activities during this period when soil contamination of skin injuries could easily occur, since more people spend more time out-of-doors.

Conclusion

Ninety-nine cases of tetanus involving patients ranging from one week old to ninety-four years of age were reported from 1959 to 1964. Ninety-seven of these patients lacked active tetanus immunization. Only two of these ninety-nine patients were known to have had some form of tetanus inoculation, and both of these patients survived after contracting tetanus. All fatalities occurred in the group without a history of immunization. In the unimmunized group, survival rate was 43 per cent. The difference in survival rate between the immunized (100 per cent) and the unimmunized (43 per cent) groups is great enough to warrant promotion of tetanus immunization regardless of age. Fatality occurs in all ages, especially among certain age groups and occupations in which there is a high risk of tetanus.

In the popular imagination tetanus is more menacing and enigmatic than other diseases because of the generally futile therapeutic measures (being purely supportive). The most effective procedure is immunization of susceptibles before invasion by *Clostridium tetani* occurs.

Contrary to popular speculation that one can postpone tetanus immunization until children enter elementary school, the data revealed that early active tetanus immunization in preschool children (the group zero to four years of age) is highly warranted because it is life-saving.

Protection of these children from tetanus is among the most momentous and far-reaching of all preventive medical services. Delaying tetanus immunization among preschool children cannot be condoned. The rationale for active immunization cannot be overemphasized. By learning how to prevent tetanus, man has entered a new era that promises health and even longevity.

Whatever insight might be gained from a survey presentation, equally pertinent recognition can be made of the fact that highly effective preventive measures against tetanus were developed some 30 years ago. These measures have withstood the test of time in being overwhelmingly effective and competent in breaking the chain of disease transmission. The present case distribution, reflecting heavy contributions from both extremes of the age scale, points

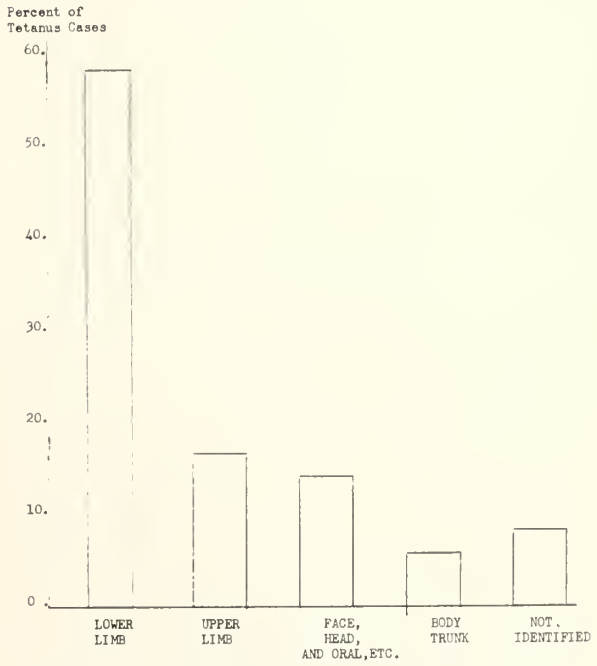


FIG. 4. *Per cent of cases of tetanus by site of lesion (Ohio 1959-1964).*

cogently toward the necessity for concerted efforts to prevent tetanus among preschool children and elderly people. Furthermore, since none of the observed cases (except two) had previous tetanus immunization this disease can be prevented by immunization, as has been more than sufficiently documented in the past. Immunization against tetanus is a striking illustration, dynamically revealing how man adapted to his diverse environment.

Summary

Ecologic factors continued to predominate in the epidemiology of tetanus. Eighty-three per cent of 99 cases occurred in rural farm communities: 59 cases among farmers and 24 cases among nonfarmers by occupation in the same type of environment.

A survey of 99 cases shows a predilection for the 45 to 54 years age group — the population segment selected for the highest risk of reported clinical tetanus. The age-sex specific morbidity rate was highest among males over 54 years of age. Seventy-four per cent of cases involved wounds of the limbs and 13 per cent had wounds of the face, head or oral cavity. The group under five

years of age experienced considerable morbidity and mortality contradicting the claim that tetanus immunization can wait until children start elementary school. Most cases of tetanus occurred between April and October.

Acknowledgment: Review of the statistical data and accompanying graphs was done by William P. Chu, Biostatistics Consultant, now with Social Security Administration, Baltimore, Maryland, formerly with the Ohio Department of Health, Columbus, Ohio.

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HIATUS HERNIA — Following are indications for surgical treatment of hiatus hernia:

(1) Dissatisfaction of the patient with symptomatic relief after six months' conservative treatment or unwillingness to continue such treatment. Certain patients have severe pain with only minimal evidence of oesophagitis, and surgery should not be withheld simply because of the absence of gross pathological changes.

(2) Persistence of oesophagitis after six months' medical treatment and the development of peptic ulcer in the oesophagus or in the stomach at the level of the hiatus.

(3) Signs of a stricture developing. If mild this may respond satisfactorily to a simple reparative operative, but if it is tight and causing nutritional impairment resection with interposition of a jejunal loop or taking the stomach into the chest is mandatory.

(4) Recurrent bleeding in a younger person is best treated surgically, but the elderly often do well with conservative measures in such a situation.

(5) Occurrence of aspiration pneumonia.

(6) Incarceration or strangulation is an urgent indication for operation.

Unfortunately hiatus hernia is common in the older age group, where other disease, notably cardiac ischaemia, often coexists. Here the risk of operation, intrathoracic or intra-abdominal, might be judged too great even in the presence of the above indications and no choice is left but to continue medical measures. — Michael Atkinson, M. D., F. R. C. P., Worcester: *British Medical Journal,* 4:221, October 28, 1967.

Benign Lymphoepithelial Lesion Of the Parotid Gland

ABDUL F. NAJI, M. D., W. F. BOUKALIK, M. D., and GHAZI MASSARANI, M. D.

IN THE PAST the names Mikulicz disease and Mikulicz syndrome have been indiscriminately used to label a variety of neoplastic and inflammatory disorders which affect the salivary and lacrimal glands. Presently most of these lesions, characterized by abundant lymphocytic components, are being properly classified according to their histologic types.

Varying degrees of lymphocytic infiltration may accompany chronic inflammation, granulomas, and carcinomas of the salivary glands. Within the salivary glands, cysts or lymphoepithelial aggregates, representing branchial cleft rests, may be encountered. In 1929, Warthin[1] first described the lesion known as Warthin's tumor or papillary cystadenoma lymphomatosa. Observers agree that this is a true benign neoplasm which affects the salivary glands. Finally, the salivary glands may become involved with any one of the malignant lymphomas: lymphocytic, lymphoblastic, reticulum cell, or Hodgkin's disease. This may be the result of extension from cervical lymph nodes or, more rarely, of a primary tumor arising from intraglandular lymphoid elements.

The true nature of the so-called benign lymphoepithelial lesion of the parotid gland remains vague. It is characterized by partial to total absence of salivary acini, marked lymphocytic infiltration, and salivary duct metaplasia. At the present time this lesion is being erroneously diagnosed as a neoplasm and labeled adenolymphoma, solid adenolymphoma, lymphoepithelioma, adenoma lymphomatosa, sebaceous adenoma, Mikulicz disease, etc.

We feel that the lesion is inflammatory rather than neoplastic. Furthermore, the pathologic findings in this disease bear close resemblance to those seen in a rare type of severe chronic thyroiditis classified as a fibrous variant of struma lymphomatosa with marked squamous metaplasia.

Material and Method

Four patients who had benign lymphoepithelial lesions of the parotid gland were studied. The clinical data from the hospital records were summarized. Follow-up information was obtained from the patients' physicians. The gross and microscopic appearance of the lesions were studied. Hematoxylin and eosin, connective tissue, reticulum, mucin, and lipid stains were used. Cases previously reported in the literature were reviewed.

Submitted June 15, 1967.

The Authors

- Dr. Naji, Cleveland, is Director, Department of Pathology, St. Alexis Hospital.
- Dr. Boukalik, Cleveland, is Medical Director, St. Alexis Hospital.
- Dr. Massarani, Cleveland, is a member of the Surgical Staff, St. Alexis Hospital.

Results

Clinical Findings:

Our four patients were white women with an age range of 28 to 50 years. The median age was 39.5 years. The duration of the disease was from one to four years. In one patient, the lesion involved both parotid glands. Another patient had a right parotid lesion with slight diffuse enlargement of the thyroid gland (tissue examination of the thyroid gland was not done). The other two patients had right parotid gland lesions. In all patients the parotid glands revealed a painless, nontender, firm nodule, measuring 3 to 6 cm. in diameter. The skin covering the lesions was movable and of normal color. No regional lymph node enlargement was noted. The physical examinations were otherwise negative.

The previous history of the patients revealed no significant findings other than childhood diseases, including mumps. In all patients the routine urine and blood findings were within normal limits. The peripheral blood and bone marrow pictures were normal. Serum electrophoreses were normal. Thyroglobulin antibody titers were negative. In the

patient who had the bilateral parotid lesion, the thyroid complement fixation test was anti-complementary. In the other three patients, the thyroid complement fixation tests were negative.

In all four patients the parotid gland involved by the lesion was excised. None of the patients had recurrence four to five years after surgery. At the present time, all are enjoying normal health.

Pathologic Findings

The pathologic findings observed in our cases are similar to those described in the literature. The gross appearance of the lesion varies with the degree of involvement of the parotid gland. In the early stages, discrete, slightly firm nodules are seen separated by less involved soft parotid gland tissue (Fig. 1). In more advanced cases, a lobulated, firm mass may be seen with a sharp, well-circumscribed outline and a firm, tan, uniform or slightly granular cut surface (Fig. 2). The size of the lesion varies from 1 to 7 cms. Partial or total encapsulation is occasionally described. When intraductal keratosis is excessive, yellowish, greasy foci may be noted on the cut surface.

Microscopically the lesion has a lobular pattern reminiscent of the salivary gland lobules. These lobules are separated by fibrous septa, which are continuous with the salivary gland capsule. In early lesions the microscopic findings are patchy and nonuniform, and some salivary gland lobules may appear to be entirely normal (Fig. 3). A thin lymphocytic infiltration with occasional plasma cells is present within the stroma surrounding intact salivary glands and ducts. In more advanced cases, there is partial to total lack of salivary acini with replacement by diffuse lymphocytic infiltration and fibrosis (Fig. 4). The lymphocytes are of a small mature type. Germinal centers and reticulum cell hyperplasia may also be seen.

Within the lymphoid tissue are scattered epithelial nests in varying numbers. Under close examination, these nests prove to be salivary ducts which have undergone morphologic alteration. The changes may be slight and inconspicuous or the ducts may be found totally transformed into solid epithelial nests. All grades of ductal metaplasia between these two may be observed. There may be circumferential metaplasia or the metaplasia may involve only one side of the duct wall (Fig. 5). In the early stages, the uniform epithelial lining is lost and is replaced with ill-defined cells having no intercellular boundaries. The nuclei lose their uniform distribution and are irregularly scattered within the cytoplasm.

In more advanced cases, the ductal epithelium becomes markedly thickened. Vacuolated epithelial lining cells are frequent, and on occasion, squamous metaplasia is observed. The squamous cells appear in uniformly arranged sheets with intercellular bridges and centrally located nuclei. They do not show any dysplastic changes (Fig. 6). Within the squamous epithelium, large cells having the appearance of sebaceous cells are occasionally noted. Lesions having this latter characteristic have been referred to as intraparotid sebaceous glands, sebaceous lymphadenoma, etc. (Figs. 7 and 8). Dilated ducts lined by metaplastic epithelium may contain inflammatory exudate, acidophilic material, or calcific debris.

The amount of fibrous reaction associated with the lesion varies. In some areas, solid masses of lymphoid tissue with scarce fibrous background are noted. In other areas, scanty to abundant fibrous and hyaline tissue can be seen within and around the involved salivary gland lobule.

Discussion

In 1935 Carmichael, Davis, and Stewart[2] reported eight cases of papillary cystadenoma lymphomatosa, referring to them as adenolymphomas. Gaston and Tedeschi[3] used the term "adenolymphoma" to designate "any tumor" of the salivary glands whose morphology consisted of combinations of epithelial and lymphoid elements, whether benign or malignant. Lloyd[4] reported seven cases of "salivary adenoma and adenolymphoma." The histologic description of most of his cases suggested that the lesions were similar to those of our present cases. However, a photomicrograph of papillary cystadenoma lymphomatosa was included with his illustrations. A malignant lesion which he referred to as "syncytial reticulosarcoma" was described in one case.

Another group of observers reported incidents of this disease under the title of "sebaceous gland adenoma" of the parotid gland. Hartz[5] in 1946, described the development of "sebaceous glands" from the lobular ducts of the parotid. These glands were located in the uninvolved salivary ducts in a case of mixed tumor. The presence of "sebaceous glands" in a normal and a diseased parotid gland was also reported by Lee[6] and Meza-Chavez.[7] Since then several reports of "sebaceous gland" lesions of parotid gland have appeared in the literature. Rawson and Horn[8] reported two cases of tumor characterized by structures "indistinguishable from sebaceous glands." They also mentioned similar changes in salivary gland tissue resected with a cylindromatous tumor of the parotid gland. Two similar cases of "sebaceous lymphadenomas" were reported by McGavron, Bauer, and Ackerman.[9] The authors believed this lesion to be a distinct benign neoplasm "of the parotid salivary gland."

Another case of "sebaceous lymphadenoma" was reported by Barton.[10] More recently Cheek and Pitcock[11] reported a case of "sebaceous lymphadenoma" and another case composed predominantly of "sebaceous cells" with a minor mucin-producing component which was thought to be of low grade malignancy.

Several recent authors have expressed some doubt as to the neoplastic nature of this lesion. Godwin[12]



Fig. 1. Gross specimen. Early inflammatory lesion of parotid gland. Multiple nodules separated by less involved tissue.

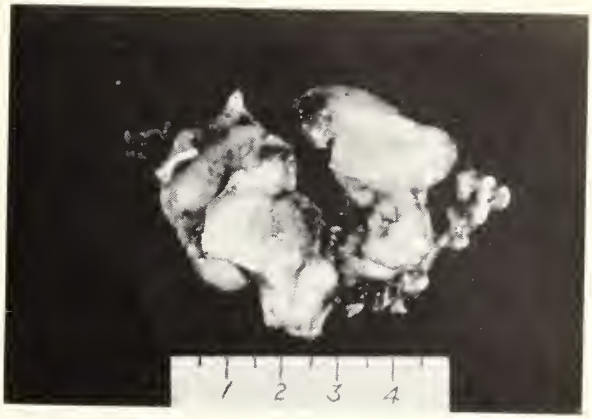


Fig. 2. Gross specimen. Advanced inflammatory lesion of parotid gland. Solid lobulated mass closely resembling neoplasm.

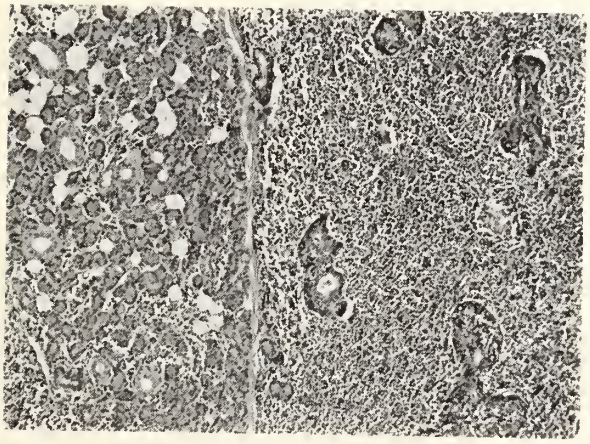


Fig. 3. Photomicrograph. Two parotid gland lobules with interlobular septum. Right: marked lymphocytic infiltration, metaplastic epithelial nests, total loss of salivary acini. Left: relatively normal lobe. H & E. X100

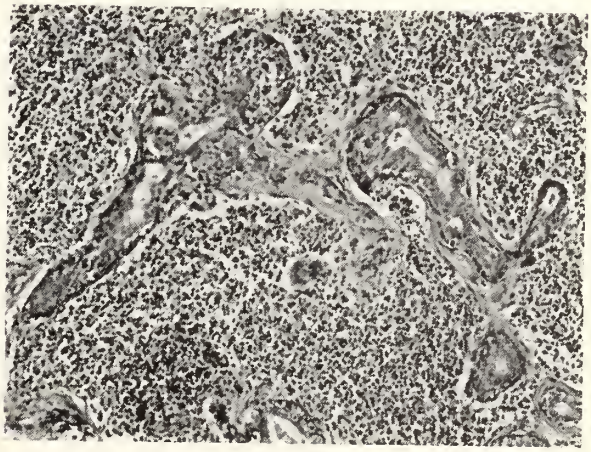


Fig. 4. Photomicrograph. Moderately advanced lesion of parotid gland. Partial loss of acini, ductal metaplasia and dense lymphocytic infiltration. H & E. X150

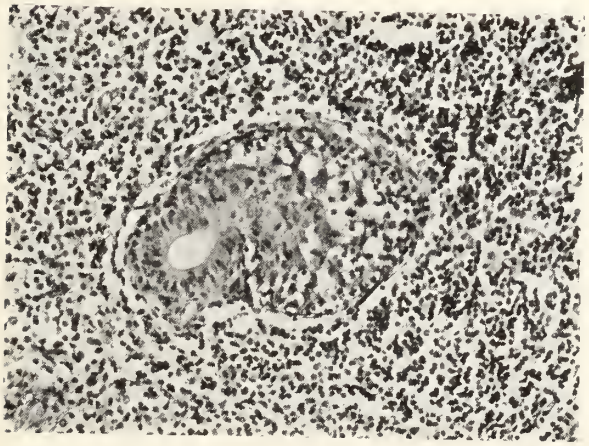


Fig. 5. Photomicrograph. Parotid gland. Ductal metaplasia involving one side of the duct. NOTE: Vacuolated epithelial cells. H & E. X250

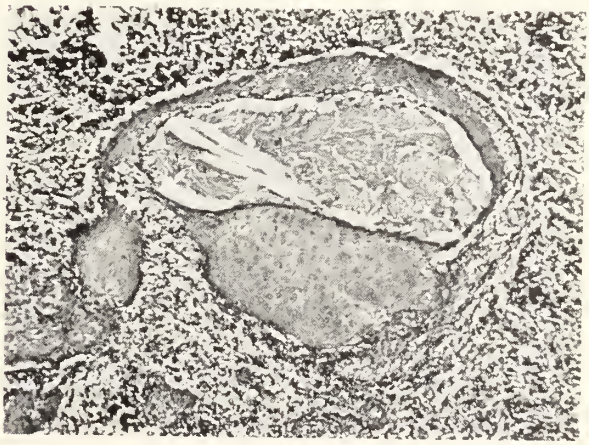


Fig. 6. Photomicrograph. Parotid gland. Squamous metaplasia of ductal epithelium. Lumen contains lipid clefts and keratotic cells. X100

believes that the encapsulated lesions are true neoplasms, while the nonencapsulated are likely to be inflammatory. He was the first to apply the name "lymphoepithelial lesion" to this disease. In Bernier's[13] opinion the entire disease represents hyperplasia of lymph nodes that extends into the salivary glands. He suggested that the lesion be called lymphadenitis. Foote and Frazell[14] were more impressed by the "neoplastic qualities" of the lesion, although they admit that there are examples that justify Godwin's preference of terminology. Morgan and Castleman[15] believe that the lesion may be a part of the Sjögren syndrome. Smith[16] does not believe that it is a true neoplasm. He feels that due to inflammation, the lymphoid tissue within or surrounding the parotid gland undergoes marked hyperplasia.

The foregoing illustrates the divergence of concepts concerning the nature of this lesion. We believe that it is inflammatory, not neoplastic. Although abundant lymphoid elements are present in both papillary cystadenoma lymphomatosa and the lesion under discussion, we feel that these diseases are entirely unrelated. The former is a benign neoplasm and the latter an inflammation of the parotid gland. The concepts of Gaston and Tedeschi and Lloyd regarding these lesions are obviously not accurate since they have included both inflammatory and neoplastic, benign and malignant lesions under one category. The terms "sebaceous adenoma" and "sebaceous glands" occasionally used to describe these lesions should be discouraged. When hyperkeratosis is marked, the duct content bears a close resemblance to that of an epidermal inclusion cyst in both the gross and microscopic appearance. Godwin's classification of the lesions as inflammatory or neoplastic according to the presence or absence of a capsule is not realistic. We feel that the capsule which is occasionally found surrounding some of these lesions is, in reality, a fibrous proliferation of the parotid gland capsule or the interlobular septa. We do not agree with Bernier, who considers the entire disease to be a lymphadenitis extending into the salivary glands, since in our cases there was no significant cervical lymph node enlargement. The entire lesion appears to be within the parotid gland itself. There were no other clinical or pathological findings suggestive of the Sjögren syndrome.

The distribution of the lesion, especially in the early stages, is nonuniform and appears to be multifocal. In more advanced cases, the lesions become matted together forming large nodules, which may be easily mistaken for a neoplasm.

In the early stages only scanty, chronic, inflammatory cells are seen surrounding intact salivary acini. The inflammatory cellular infiltration is mainly lymphocytic, but occasional plasma cells may be observed. Transition from this obviously chronic inflammatory process to a more severe dense lymphocytic infiltration with total disappearance of salivary acini and marked ductal metaplasia is gradual. All grades of severity between these two may be seen. The lymphoid tissue represents lymphocytic infiltration and/or local lymphoid hyperplasia.

Smith observed the presence of lymphoid aggregates within the parotid gland in human embryos and fetuses. These may become the source of lymphocytic supply in certain diseases of the parotid gland. The presence of active germinal centers within the lymphoid tissue is commonly seen in inflammatory processes.

The occurrence of all grades of ductal metaplasia and the partial involvement of many ducts also suggest an inflammatory nature. Occasional bilateral involvement of the parotid gland neither proves nor disproves that the lesion is inflammatory.

Finally, it has been observed that these lesions are frequently associated with fever or upper respiratory infection.

The histological resemblance of this lesion to one type of struma lymphomatosa of the thyroid gland is demonstrated in the following case.

A 37-year-old housewife was admitted to the hospital in October 1947 with the diagnosis of myxedema. The thyroid gland was bilaterally enlarged and slightly painful. Her basal metabolic rate was minus 31. In January 1948, she was readmitted after receiving a course of thyroid therapy. The myxedema showed considerable remission and the thyroid gland had decreased in size. Thyroidectomy was performed.

The surgical specimen weighed 18 gms. and measured 5 by 3.5 by 2 cms. The outer surface was reddish-gray and the cut surface was pale reddish-gray and slightly firm. Microscopically there was no identifiable thyroid tissue. Scattered lymphocytic aggregates and germinal centers were seen within dense fibrous and collagen tissue. Most of these aggregates contained spherical or oval acini. The acini were lined by cuboidal or columnar cells having centrally-located nuclei and acidophilic cytoplasm (Fig. 9). Varying degrees of epithelial metaplasia were noted in the epithelial lining, including pseudostratified columnar epithelium and the formation of solid nests of squamous epithelium (Fig. 10).

Comment

The gross and microscopic appearance of the thyroid lesion in this case has a striking resemblance to that of the parotid gland lesion discussed earlier. Both lesions are characterized by parenchymal atrophy, marked lymphocytic infiltration with fibrosis, and epithelial metaplasia. Although the histologic appearance in the final stages is similar, we realize that the metaplastic changes in the thyroid gland lesions are more complicated than those of the parotid gland. Since the normal thyroid gland does not possess ducts, it is assumed that the metaplasia takes place in the acinar epithelium. Many of these acini retain a columnar epithelial lining and a large number undergo marked squamous metaplasia, with or without keratinization. Hazard[17] believes that this thyroid lesion is an unusual variant of diffuse lymphocytic thyroiditis, and he classifies it as struma lymphomatosa, fibrous variant with squamous metaplasia.

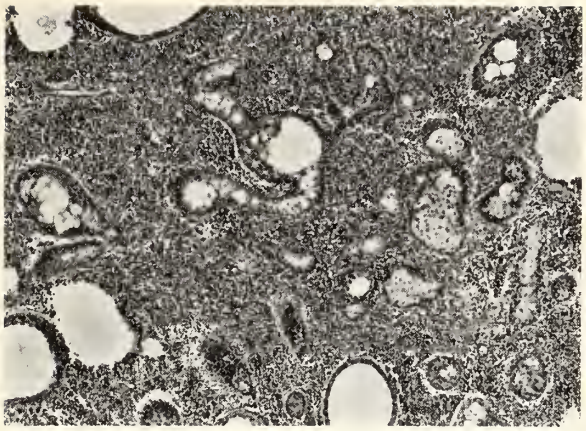


Fig. 7. Photomicrograph. Parotid gland. Metaplastic epithelial nests resembling sebaceous glands. Also seen are dilated ducts with early metaplasia. H & E. X100



Fig. 8. Photomicrograph. Parotid gland. Metaplastic epithelial nests resembling sebaceous glands. Stromal lymphocytic infiltration. H & E. X250

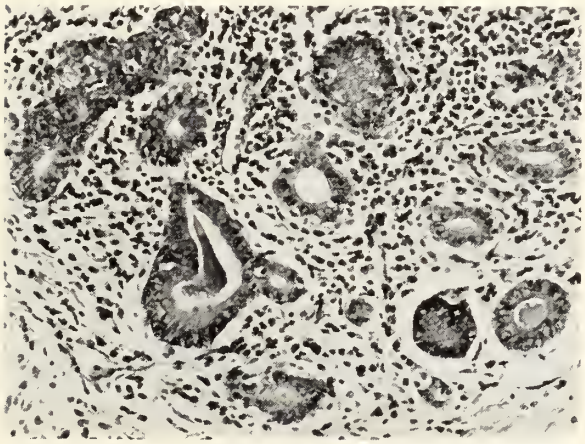


Fig. 9. Photomicrograph. Thyroid gland. Lymphocytic aggregates containing metaplastic tubular structures. H & E. X250



Fig. 10. Photomicrograph. Thyroid gland. Lymphocytic aggregates containing metaplastic squamous epithelial nests. H & E. X100

Finally, these diseases of the parotid and thyroid gland both affect women more often than men. In Godwin's series, eight out of eleven patients were females. All lesions studied by us occurred in women. Since these lesions of the parotid and thyroid glands are similar in many aspects, it is possible that they have a common etiology.

Since the morphologic features of this parotid gland lesion are consistent with those of an inflammatory process resembling chronic lymphocytic thyroiditis (struma lymphomatosa), we recommend the term chronic lymphocytic sialoadenitis for its designation. We do not believe that this disease is related to bacterial sialoadenitis or other inflammatory salivary gland lesions which may accompany salivary gland calculi. The possibilitiy of an auto-immune mechanism as an etiologic factor needs further investigation. Mumps can be ruled out as a cause of this salivary gland disease. In none of the reported cases was there mention of recent clinical history of mumps. All four of our patients had had mumps with uncomplicated recovery during childhood.

Summary

1. Four cases of benign lymphoepithelial lesions of the parotid gland and one case of struma lymphomatosa (fibrous variant) of the thyroid gland are reported and the literature is briefly reviewed.

2. We believe that the parotid gland lesion is inflammatory and bears marked resemblance to struma lymphomatosa of the thyroid gland.

3. We suggest the term chronic lymphocytic sialoadenitis be used to designate the parotid gland lesion.

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SYMPATHECTOMY FOR CLAUDICATION.—The value of lumbar sympathectomy for intermittent claudication is disputed. Improvement would imply persistent release of collateral or vasomotor tone. It is doubtful whether afferent fibres are carried in the sympathetic trunk in sufficient number to be of significance. Thirty-one patients having 40 lumbar sympathectomies for intermittent claudication were studied before and 10 to 14 days after operation by strain-gauge plethysmography. Measurements were made of the resting flow, of the peak flow and time of its development during reactive hyperaemia, and of the distal arterial pressure in the calf muscle. No statistically significant increase could be demonstrated after sympathectomy in any of these parameters in the group as a whole. Nor could significant change be shown according to the clinical response to the operation, to the severity or duration of the symptoms, or to the site of the occlusion or extent of the disease. The flows both before and after sympathectomy were higher in the group showing clinical improvement, suggesting that spontaneous remission is more likely to occur when the disease is less severe. It is considered that there is no objective evidence of consistent haemodynamic benefit from lumbar sympathectomy for intermittent claudication.—K. A. Myers, M. B., F. R. A. C. S., and W. T. Irvine, M. D., CH. M., B. SC., F. R. C. S., London: *British Medical Journal*, 1:883, April 9, 1966.

The Last Great Northwest of Surgery

CLAUDE S. BECK, M.D.*

AS A STUDENT and as an interne at the Johns Hopkins University I was impressed by the greatness of this Institution. Research was a big word and the professors were intellectuals. A few memories relating to greatness are mentioned. Dr. Hugh Young, the world famous urologist, was doing an operation for hydrocele when suddenly the patient died. I was passing instruments. A hush came over the operating room. Suddenly Dr. Colston, the first assistant, ran to the telephone and I wondered how anyone could make a telephone call at this crisis. Then I heard the clanking of the Baltimore Fire Department on Monument Street. Two firemen came in with a pulmotor. They placed the pulmotor over the dead man's face. Time passed. He remained dead. To me, no one, nowhere, would have had the foresight to have made that telephone call. This could only have happened at The Hopkins and I was again impressed by her Greatness. The years have passed by but this is fresh in my memory as though it happened yesterday. You will forgive me I hope if I say that I have changed my mind. I don't believe we surgeons should turn these emergencies over to the fire company. We should take care of them ourselves.

Another manifestation of greatness was in the attitude of the surgical residents. They were as perfect as could be. If they operated for appendicitis all the requirements for the diagnosis had been fulfilled. If the patient did not have appendicitis then it was the patient who was wrong. This created the pleasant glow of self righteousness. I learned something by the following episode. Doctor Finney had Professor Halsted see a patient at the Union Protestant Infirmary. Surgical operation was done. Doctor Halsted's diagnosis was wrong. Doctor Finney's diagnosis was correct. The following comment was made. "Finney, on what did you base your diagnosis?" Answer, "Just a hunch, Professor." Whereupon Halsted said "I would rather be wrong with reason than right without reason." How could an interne interpret this? Was it the sublime in logic or was it the arrogance of being Professor?

The next year I was at the New Haven Hospital. There, nothing was perfect. I never knew how bad things could really be. Everyone was criticized. I felt that I had made a mistake by going there. Then suddenly and almost for the first time I began to think for myself. In the discomfiture of having to defend myself I had grown up. The next year at Harvard and the Brigham, Doctor Harvey Cushing put me to work in the Research Laboratory under Elliott Cutler, who was cutting the stenosed mitral valve. Doctor Cushing stated that The Heart was the Last Great Northwest of Surgery. Under his handiwork, skill and endurance Brain Surgery had occupied that position but now the heart was going to have opportunity.

In my innocence I wondered why Professor Halsted at the Johns Hopkins never thought of that. I began to contemplate the definition of Greatness. Doctor Cushing helped me with his biting criticisms such as "Finney is not the man for that job at Hopkins." "A case report does the most good to the young surgeon who makes the report because he learns how to use the inkpot." At a formal dinner for Sir D'Arcy Power I arrived late because of streetcar difficulty. He greeted me at the door and said "Beck it was so good of you to come." There was only one person Doctor Cushing spared with his criticisms and that was William Osler whose biography he was writing. "Beck, here's a letter from Welch about Osler. I just received it." When I went to Boston to get the laboratory job he had me, a stranger, stay for dinner. Then he walked me down to the streetcar line and as I got on he told me that I had the job. Years later at his funeral in Cleveland Mrs. Cushing told me that she wept after that interview because he talked to me as he never talked to his own son.

But I must get on with my own story. I came here with Doctor Elliott Cutler, who succeeded Doctor George Crile in 1924. For the next 40 years here at the Lakeside Hospital the Heart, for me, was the Last Great Northwest of Surgery. Another year was spent in the Research Laboratory and then the Residency in Surgery. Later on three-fourths of my time was in Research. I did not know what private practice was. I became a pampered, critical young man like Cushing must have been and it took some time for me to become the nice person that I really am. I hear no laughs so I guess I got by with that one.

I believed then, as I believe now, that criticism of existing "knowledge" is necessary for progress. If

*From a printing of the text of an address delivered to the Surgical Residents' Reunion on the eve of his retirement as Professor of Cardiovascular Surgery, Case Western Reserve University, Cleveland, July 1, 1965.

knowledge is to be discovered, then criticism must be encouraged and the critic, who is always unpopular, may need to be protected. Otherwise the University may get rid of him. There was no heart surgery but early in my work I had several beliefs that made me stay with the heart. One of these concerned the nature of cardiac problems. Most cardiac disabilities were mechanical. That meant that many of them should yield to mechanical repair and that meant surgical operation. History has proved the correctness of this axiom and I don't believe it was recognized by any other person in the entire world — I never heard it stated.

Another tenet that supported my solitary position was the use of vision on the heart. No one used vision except the physiologist and his vision was confined to the "acute" experiment. Not available to him was the "long-term" experiment and the "control" experiment because he could not make them. Further the physiologist lacked contact with the sick cardiac patient and knowledge of cardiac disabilities was denied him. The medical cardiologist had the electrocardiogram and this fulfilled his every wish To him the heart was covered as by a blanket but that did not matter. Doctor George Crile told me that "the cardiologist lets the electrocardiogram do his thinking for him." In my opinion this statement was essentially correct. As a tool for study, surgical visualization was more important than the electrocardiogram but I was the only one who knew it.

I want to return to the early activities in the surgical laboratory at the old Lakeside Hospital, 1924 to 1932. Doctor Cutler was having difficulties and disappointments with the mitral valve work. The valves operated upon were heavily calcified and it seemed that it was necessary to cut out a piece of the valve and create regurgitation. I made an instrument for this purpose. Mortality stayed the surgeon's hand. The bloom was coming off the mitral valve work. There was no one to encourage Doctor Cutler to keep on with the problem. His total experience was with 10 human patients plus a lot of experimental work. He was just learning how to operate on the heart. Each operation involved a great emotional response. Experience was needed and how could experience be obtained! The results were not good enough to break the barriers of resistance.

It was I who got the most out of this experience. In the laboratory an operation was done almost every day and I was learning how to handle the heart. I had to turn to other problems. When I was an interne Doctor Halsted had an experience which gave me a lead. He irrigated a biliary fistula with Dakin's solution and the patient died of peritonitis. It eroded the bowel. What would Dakin's solution do in the pericardium?? It produced adhesions between the heart and pericardium. It also produced Pick's Disease. These observations were readily made and they had immediate application to the patient. At that time the Brauer operation of cardiolysis was occasionally done for adhesions between heart, pericardium and chest wall. The precordial ribs were removed to make a soft yielding precordium. When it was shown that adhesions scarcely ever disturbed the heart this operation was discontinued. Pick's disease became known as Chronic Cardiac Compression. The scars were resected on dogs and this brought us almost all of the heart surgery that was being done in this country at that time.

Acute compression of the heart was also investigated and this got us started on stab wounds of the heart. A simple method of suture was described. One thing led to another. The penetrating wounds introduced us to the non-penetrating wounds and the steering wheel accident. This was the most common type of cardiac wound and we directed attention to it. It might be mentioned that the first operation on the heart was for a stab wound. It was done by Alex Cappelen of Copenhagen in 1895. With this operation the heart entered the domain of surgery. Since then many penetrating wounds have been sutured and some of these reports are of high adventure, such as the surgeon who was blinded by blood spurting up on his glasses when the pericardium was opened, then the patient recovered consciousness and began moving off the operating table and to cap the climax respiration returned and this churned the blood into a foam which hid the heart from view. Nowhere does a little experience mean so much to the surgeon as when he stands on his own at the operating table to repair a wound of the heart.

There was an abundance of problems for study. Doctor Cutler suggested that I prepare myself to ligate the Patent Ductus Arteriosus. We did experiments on newborn puppies to see what the duct looked like. Our artist, Theodora Bergsland made a beautiful drawing of the anatomy in a child who had died. We were anxious to do the first operation but our Department of Pediatrics was not surgically oriented and I never saw a duct in the living state. The first ligation together with our beautiful anatomical drawing followed Cutler to Boston and the Children's Hospital where after several years the first operation was done.

We also made septal defects. This was in 1924 to 1926, long before John Gibbon came on the scene. It might be of interest to note that sometime after Doctor Lenhart became Professor of Surgery in 1932 John Gibbon came here looking for a job in surgery. We were the only surgical center investigating the heart. Work done elsewhere by surgeons was of a sporadic nature based upon a few experiments. There was no sustained effort anywhere except here. For many years we were in this unique position. I used to blush when anyone said that I was a Heart Surgeon for there wasn't any Heart Surgery. I had freedom to work and I had an abundance of energy.

I appreciate the value of these two assets more now than I did then. However, I was beginning to feel a loneliness in the laboratory. I needed scientific companionship and I had none. This loneliness persists up to the present time. I became Professor of Neurosurgery and I did research on the heart. Doctor Lenhart suggested that I give up the heart work, "I had a family to support." This troubled me for I respected his opinion. Not that research on the heart made me any less competent as a neurosurgeon but it was a mixed marriage and perhaps it might have been better if I did no research at all. This would have kept me out of trouble but it would have been no fun. I was busy as a neurosurgeon. Now it makes me tired when I look in and see a bone flap and I wonder how I had this endurance for 20 years.

The heart work was receiving attention. I had invitations to present it in almost every city in this country. Helen Taussig had me down to Hopkins to tell about it and later on after the Blue Baby operation was *"fait accompli"* she declared her willingness to come to Cleveland and work with us at Lakeside (behind every man there is a woman — Blalock). Russell Brock was here from London, George Mason from Newcastle and many others came and visited. This did not help me any for now I was being looked upon with suspicion. This cloud of suspicion lingers on and we here at Lakeside will be the last to see it disappear.

Coronary Artery Disease, Death and The Dying Process 1932-1965

People have asked me why I studied coronary artery disease. There was no special reason. It killed and incapacitated a lot of people. It needed what aseptic surgery could give as a research tool; namely, vision, "long-term" experimentation and the "control" experiment. We did not know where we were going and what we were going to accomplish. You might be interested to know that some eight thousand experiments were done on dogs at a cost of about half a million dollars. Many of you present spent a year or two in the laboratory and Dave Leighninger spent 15 years on the subject. Those of you who did the work deserve full credit and your names are on all publications. We were always slow to learn but I might say that when a fact was established it had stood the test of time.

Several salient facts were established. We produced collaterals for the first time, i.e. connections between one artery and another. We measured what the collaterals could do. We tested methods of producing them including an A-V fistula in the heart and this became the Beck II operation. We tried to augment blood flow into the heart through grafts. We avoided removal of anatomical disease in arteries and left this approach to others. We reversed the fatal heart attack. We defined the two forms of death and we investigated each. The remainder of this historical account is given under the names of the two physiologists whose contribution laid the groundwork for most of what we have done — names with which you are probably not familiar and they have great historical significance.

Jean Louis Prevost and Frederic Battelli

These physiologists contributed the method to defibrillate the heart by passage of an electric shock through the heart or through the intact chest. The title of their paper was *La Mort Par Les Decharges Electriques* published in the *Journal de Physiologie et de Pathologie Generale,* Vol. 1, p. 114, 1899. The significance of this contribution is based upon the following considerations.

1. The electric shock is an effective method to defibrillate the ventricles. It is the only effective method.

2. Ventricular fibrillation is a common cause of death. The fatal heart attack claims about 500,000 victims a year in this country. Many of these victims can be made to live again if the right thing is done at the moment of death.

3. The fact that these victims live, sometimes for years, with the same heart without removing anatomical disease in arteries and muscle calls for discovery of the death-factor that makes this possible. The death-factor was discovered and reported in the *JAMA* 159:1264, 1955. Death is due to an electrical charge produced by oxygen-differentials in heart muscle. These differentials are produced by uneven blood supply to heart muscle. The heart electrocutes itself. The importance of this discovery should not go unnoticed. Up to then and, indeed, up to the present time the heart attack was always produced by occlusion of a coronary artery. This, in turn, produced injury to muscle due to ischemia. If the patient lived he developed a scar. If he died he developed a current of injury which killed. There were many victims of the fatal heart attack with little or no disease in arteries or muscle. There were many deaths that could not be explained on the basis of anatomical disease. There simply was no explanation. The electricity produced by oxygen-differentials brings these victims under the umbrella of science. It is difficult to appreciate this vacuum in science concerning such an important subject and existing up to such recent times.

4. If death can be reversed after it occurs something can be done to prevent death or to delay death before it occurs. This something is to reduce the oxygen differential by making blood supply more even by collaterals. These are connections between one coronary artery and another.

Please note that this form of therapy is not based upon reduction of anatomical disease. It is based upon collaterals to reduce anginal pain and to reduce the incidence of electrical fibrillation. The



Jean Louis Prevost
(1838 - 1927)
Professor of Physiology
University of Geneva
1897 - 1913

vasodilator drugs open collaterals for short periods of time. The author's operation is five times as effective and it is permanent. This approach is away from anatomical disease. It is applied to Hearts that are Too Good To Die, to Hearts that have Mileage left in them, to Hearts that only need a Second Chance to Beat. Removal of anatomical disease by opening up the coronary arteries has its place in therapy, small as it is, especially when it approaches the terminal state. For the good heart or the relatively good heart the production of collaterals by surgical operation should be standard treatment for the disease. (*Ann. Surg.*, 102:801, 1935, ibid 145:539, 1957).

Discussion

Concerning the Method by Prevost and Battelli. The method was lost in the literature for 35 years. Little importance was attached to this subject. Fibrillation was noted in the course of animal experimentation. Fibrillation, when it occurred, terminated the experiment and one learned to take another dog. In the area of human medicine, fibrillation was noted by the electrocardiogram. Almost without exception it meant death when it occurred. In the thirties the physiologist Hooker and also Wiggers worked on this subject using potassium salts to stop fibrillation and calcium salts to restore tone. In the occasional experiment the heart beat was restored. As a method it was far from adequate.

In 1934 ventricular fibrillation occurred in the course of an operation (by the writer) to remove a compression scar from the heart. In dissecting the scar away from the heart, pressure was inadvertently exerted upon the descending coronary artery. The heart fibrillated. It could not be defibrillated. In those days there was not much heart surgery being done but it was obvious that if heart surgery was to have a future a method for defibrillation was necessary. At about that time the physiologist William Howell learned of the contribution by Prevost and Battelli. He suggested to Dr. Hooker and to Dr. Wiggers that they each test the method. One study was supported by the electric utility companies and the purpose of the study was to apply it to electrical accidents. (Hooker, J., *Physiology*, 103: 444, 1933). The other study was related to fibrillation by experimental occlusion of a coronary artery. Massage of the heart was recommended be-



Frederic Battelli
(1867 - 1941)
Professor of Physiology
University of Geneva
1913 - 1941

fore the shock was applied for defibrillation. The statement was made that "the method should prove of value in revival of exposed human hearts that fibrillate during course of cardiac operations" (Wiggers, J., *Physiology*, 116:161, 1936). Wiggers also stated "the normal dog's heart can rarely be revived unless the occlusion is removed (incorrect statement) and this is impossible in man" (*Am. Heart J.*, 20: 413, 1940). These are probably the first references to human application.

Beck and Mautz presented the subject to the American Surgical Association using a motion picture (*Annals Surgery*, 106:525, 1937). This is probably the

first presentation to surgeons — and surgeons were the only clinicians who could apply the method for it had to be done in the operating room and preferably when the chest was already open. Doctor Evarts Graham was the President of the American Surgical Association. There was no discussion of "this very beautiful work" and Doctor Graham stated that the surgeons were not familiar with ventricular fibrillation.

The reader will please note that fibrillation is one of the two causes of death — standstill being the other cause. How little recognized are these two causes of death! And where would Heart Surgery be if the heart could not be defibrillated! I made preparations for defibrillation in the operating room. Sterile electrodes were placed in the operating rooms and in the accident ward. I gave many laboratory demonstrations and lectures on the subject. I had several successes in defibrillating the human heart but the brain was damaged and the patients did not recover.

This was the dawn of human application. Progress was, indeed, slow. In 1942 I requested permission to organize a Resuscitation Squad to function at the battlefront but this was not granted. I was politely told not to take the medical officers time to listen to lectures on the subject. The first successful defibrillation of the human heart was then achieved (*JAMA*, 135:985, 1947). This achievement was generally considered as nothing more than a routine example of successful Resuscitation as from drowning. However, I knew that it cut across the very fundamentals of coronary artery disease.

A formal course of instruction for physicians and nurses was started in 1950. This was a two-day teaching course carried out on dogs in our Research Laboratory. It was given each month and some 3,000 applicants were instructed. They came from various parts of the country and from abroad. This course continues at the present time and was instrumental in saving many lives. It helped to establish Resuscitation as a requirement in the formal education of the physician and repetition of these courses helped us to perfect the technique. Mouth-to-mouth ventilation of the lungs was introduced so that special instrumentation was not necessary for respiration (*New England J. of Medicine*, 250:749, 1954).

Application of the method then moved to the medical wards, (*JAMA*, 162:111, 1956), to the doorstep of our hospital where an M. D. dressed in street clothes had a fatal heart attack; it was reversed and the victim is alive years later with the same heart (*JAMA*, 161:434, 1956). I advocated that open chest defibrillation be done outside the hospital. This step encountered hostility by the Dean of Western Reserve University Medical School. Open chest defibrillation was then done successfully on victims who died outside the hospital (*JAMA*, 175: 141, 1961). Then came the closed chest method (*JAMA*, 173:1064, 1960). It was not necessary now to get your hands dirty to do it.

The final step is the training of non-medical personnel, men, women, high school students to be trained in the technique so that the victim can be transported with a viable brain to a medical center for defibrillation. The course of instruction includes 1, action at the moment of death, 2, transportation of victim with a viable brain to a medical center, 3, application of defibrillating shock and care of the victim. Defibrillation of the heart is more readily accomplished when the time interval between death and application of shock is as brief as possible. Therefore, non-medical rescuers will probably be instructed in this technique before the victim is transported to a medical center. Society is being informed concerning the Fatal Heart Attack by articles in lay journals, radio and television. An organization called The Resuscitators of America was organized and teaching chapters will be organized in many communities in this country. A massive teaching program will be required.

Each step in the progress so far carries the Prevost-Battelli image. It dominates the scene for restoration of life after the fatal heart attack occurs. But it also dominates the scene before death occurs. It creates the image for treatment of coronary artery disease. The fact, that the Prevost-Battelli method has provided uncounted numbers of humans now alive but who were dead, places a spotlight of inquiry as to the cause of anginal pain and the fatal attack. The cause is not "injury and injury current." This explanation is inadequate. The cause of pain and fibrillating electricity is found in the uneven blood supply to heart muscle. Arterial disease and spasm reduce inflow into a localized area of muscle. An oxygen differential between pink and blue muscle is created and this is painful and often fatal. Also well oxygenated blood allowed to perfuse an area of anoxic muscle fibrillates and kills. It is simple fact that well oxygenated blood cannot injure muscle as this term is understood. A form of treatment for coronary disease that is within our reach is to reduce the differentials in areas of muscle. This can be done by the production of collaterals (the Beck operation). The vasodilating drugs relieve pain by opening up collaterals but these are temporary while those produced by operation are five times as effective and they are permanent. The emphasis here is not on reduction of anatomical disease. It is based on a more even distribution of blood supply to heart muscle.

The Prevost-Battelli image appears in the method of defibrillation. From there it appears in living people once dead. From there it appears in the

cause of death. The cause of death is separated from injury and injury current. It is uneven blood supply. And finally the blood supply is made more even by the surgical production of collaterals. And this is treatment of the disease. This is a vast gamut of successive steps in development but the original discovery created empty slots in the science and these are just now being filled by scientific studies 65 years later. My opinion is that the Prevost-Battelli image will go down in Medical History as initiating one of the great developments in medicine. In my opinion it has the stature of William Harvey's contribution. Harvey erected the sign-posts indicating the route the blood takes in its course through the body. Having done this his contribution was finished but his name has been emulated by a grateful Great Britain for the past 300 years and his portrait is in our Institutions for everyone to revere. The Prevost-Battelli contribution continues to develop. It marks one portal to death and having entered this portal it has the power to bring some of the victims back to the living. It also prevents or delays victims from entering this portal. Their contribution has helped to give definition to the portal called fibrillation. In doing this it helped to designate and define the other portal to death namely that of cardiac standstill. These two modes of death are clinical entities that can be recognized and defined. The Prevost-Battelli contribution deserves reverence equal to that generally given to the great contribution of William Harvey.

My concluding remark was written by Mr. George Bernard Shaw — "Beware how you kill a thought that is new to you."

IMMUNIZATION NOTE — The U. S. Public Health Service and the American Academy of Pediatrics have recommended that the live attenuated mumps vaccine be considered for use in the following individuals who have not had mumps: (1) children approaching puberty, (2) adolescents and adults, especially males, (3) children living in closed institutions and summer camps, and (4) others in large groups where epidemic mumps can be particularly disruptive to normal routine. Although not contraindicated in children over 12 months of age, these authorities do not recommend routine use in infants and children until more information on the duration of immunity is available.

ASCORBIC ACID AND COLDS. — Preliminary experiments showed no evidence that ascorbic acid protected cultures against several respiratory viruses or white mice against influenza. In further experiments 91 volunteers were given either 3 g. of ascorbic acid daily or placebo tablets. Three days after the treatment began they received intranasal drops containing M rhinovirus, an H rhinovirus, a "new" rhinovirus which grows only in organ cultures, influenza virus type B, or a "new" virus related to avian bronchitis. The number, duration, and severity of the resulting colds were the same in the treated and control groups. There was no evidence that colds produced by any single virus were favorably affected. — Georgina H. Walker, M.B., CH.B., M. L. Bynoe, M.B., D.T.M.&H., and D. A. J. Tyrrell, M.D., F.R.C.P., Salisbury, Wiltshire: *British Medical Journal,* 1:603-606, March 11, 1967.

Maternal Deaths Due To Ectopic Pregnancy*

By the OSMA COMMITTEE ON MATERNAL HEALTH

With Comment of Consulting Obstetrician and Gynecologist

HEMORRHAGE is the major primary cause of maternal death in Ohio. As a contributing factor to hemorrhage, ruptured ectopic pregnancy accounts for 19.4 per cent of the deaths ranking only second to ruptured uterus (10 year survey, *OSMJ,* 63:323-332, March 1967). Indeed this is a paradox when we realize that practically *all* pregnancies in the human female start out as an ectopic pregnancy!

Herewith the Committee presents three cases of maternal death from ruptured ectopic pregnancy. All three patients were subjected to laparotomy.

Case No. 775

This patient was a 35 year old gravida IV, Para III, who died five hours postlaparotomy. Although information on her case is limited, she was a divorcee and had three previous term pregnancies without complication, and she had had no serious illnesses or operations. At 3:45 A. M. on August 10, the patient was admitted with vague, lower abdominal pain. She denied missing any periods and she denied coitus. Details of physical and pelvic examination, as well as results of laboratory studies, were not recorded. However, it appears the patient was "watched" all day for further signs and symptoms upon which to base a diagnosis.

At approximately 4:00 P. M., August 10, abdominal tenderness, "doughey" resistance and signs of internal hemorrhage appeared. At 4:30 P. M., a laparotomy was performed under Pentothal® and cyclopropane anesthetic. Hemoperitoneum (quantity large, but not estimated) was discovered, plus a ruptured left tubal pregnancy. A salpingectomy was performed, parenteral fluids administered followed by *two* units of whole blood; more was ordered from a distant city. In spite of supportive efforts the patient developed irreversible shock, pursued a downhill clinical course, and died at 9:25 P. M. before the arrival of additional whole blood. There was no autopsy.

Cause of Death (Certificate): Shock, circulatory collapse following intra-abdominal hemorrhage; ruptured ectopic (tubal) pregnancy, operated.

Comment

Regretting the lack of certain specific details in this case, the Committee studied the report. It seemed obvious that a delay in the operation caused by important information being withheld by the patient, was indirectly a factor in the patient's death. Also a lack of additional whole blood (obtained locally or from a distance) turned the final course of events. The Committee voted this a preventable maternal death.

Case No. 392

This patient was a 38 year old white woman of unknown parity who died about two hours postlaparotomy. No details are recorded regarding her past history. Separated from her husband, she apparently was living with a "boy friend." Although, it was learned, she noted some "peculiar sensations" in her abdomen, medical help was not sought. On April 11, the boy friend called a physician who saw her promptly at home; examination revealed a semicomatosed patient with no blood pressure and a thready pulse obtained only over the carotid arteries. Immediately the patient was transferred to the hospital emergency room (12:25 A. M., April 12) where alerted surgeons awaited her arrival. While she was practically moribund, "cut downs" were made over the ankles, and Levophed® solution was administered parenterally. Cross-matching was performed and type "O" negative blood was given at once with parenteral fluids.

Meanwhile, after she was admitted, in about an hour a laparotomy was performed. Approximately 3,000 cc. of blood was discovered in the abdominal cavity; the left uterine tube literally "exploded" with an ectopic pregnancy Quickly, free blood was removed and a left salpingectomy was performed. During closure of the wound cardiac arrest occurred; a thoracotomy was performed and open chest cardiac massage was carried out. Thirty minutes later cardiac activity resumed. She received a total of 2,500 cc. of whole blood during the operations. In spite of heroic therapeutic measures, the patient did not improve; she died at 3:45 A. M., April 12.

Cause of Death (Autopsy): Shock, irreversible; hemoperitoneum, massive; ruptured left uterine tubal ectopic pregnancy; hemothorax (residual).

Comment

In reviewing facts in this case the Committee noted the swiftness and efficiency with which physicians carried out measures of emergency treatment. All of the latter was considered highly acceptable. On the other hand members regretted that the patient failed to seek medical attention earlier, when symptoms appeared. The Committee voted this a preventable maternal death.

Case No. 721

This was a 23 year old, white primigravida, who died four hours postlaparotomy. Her past history was noncontributory. On June 21 the patient's husband called a physician declaring his wife "had a pain in her belly"; her

* A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

last normal menses appeared in the preceding April, and none had followed. The physician advised the man to bring his wife to the emergency room at once. When the patient failed to appear, the physician attempted to locate her, without success, since they were strangers and had left no phone number. Approximately 22 hours later the husband called again, repeating the story of his wife's condition. The man was urged to obey the previous instructions; later it was learned that the previous delay had resulted from the patient's reluctancy to enter the emergency room due to her fear of doctors, hospitals and spinal anesthesia.

About 5:45 P. M., June 22, she arrived at the hospital where she was examined immediately. A preliminary diagnosis of hemoperitoneum due to ruptured ectopic pregnancy was confirmed by culdocentesis. Preoperative medication was given and at 6:45 P. M. anesthesia for surgery was begun. The blood pressure was 104/60, pulse rate 60 per minute, the hematocrit 23 per cent. Attempts to start parenteral fluids failed due to low venous pressure; but finally, prior to surgery, fluids were administered, followed in half an hour by whole blood. Approximately a liter or more of blood and clots were discovered at operation, plus a ruptured left tubal pregnancy. Twenty minutes later (7:35 P. M.) as the wound was being closed, the anesthetist announced that the heart had arrested. Open chest cardiac massage was begun promptly with cardiac action returning. "Bag-breathing" was continued. Two units of blood, and two units of serum albumen were administered. The chest was closed, but the patient never recovered her respirations. Placed on the respirator, the patient's heart stopped at 10:45 P. M. and she was pronounced dead.

Cause of Death (Autopsy): Cardiac arrest following irreversible shock; massive hemoperitoneum; ruptured ectopic tubal pregnancy.

Comment

Noting a rather complete report, the Committee studied facts in the case with keen interest. The unfortunate delay to bring the patient to the hospital was noted. Members also felt that "cut downs" and secure parenteral routes might have been established prior to anesthesia with the administration of more fluids. An hematocrit of 23 offers a poor oxygen carrying power, eventually inviting cardiac arrest; administration of packed cells might have proven more effective. Optimism concerning the potentials of youth and eventual recovery after control of bleeding points appeared to be present; members also felt that the quantity of blood in the peritoneal cavity was *underestimated*. After a prolonged discussion, the Committee voted this a preventable maternal death.

Comment of Consultant

The following comment of a consultant, who is a specialist in obstetrics and gynecology, was given at the request of The Committee.

"Case No. 775: The significant history in this case revolves around the patient denying coitus or any aberration in her menstrual periods. We know in retrospect the former was fraudulent and undoubtedly the latter was also, for although women with ectopic pregnancies bleed sometimes at the time of their period, it is rarely what they experience typically. Obviously she was 'watched' for internal hemorrhage and ectopic pregnancy was undoubtedly considered from the beginning. Although the report doesn't say so, it appears this case occurred in a smaller town or at least one with a smaller blood bank, or possibly none at all. If this is so and blood was known to be at a premium it would seem the 'watching' should have been much more intense. A culdocentesis for *diagnosis* of hemoperitoneum is a relatively simple procedure and can be performed in any emergency room, or even in an office.

"Case No. 392: The health team whether it be doctors, nurses, or even the responsible relatives cannot constantly be 'thy brother's keeper.' The patient remains in charge of his own health status in the final analysis and his ignorance, or lack of it, and motivation contribute to his continued well-being. If any individual does not wish to receive help, then no outside force other than the law can make him get it.

In this case undoubtedly the symptoms were greater than reported but because of the patient's situation she did not seek advice until too late. As to the therapy, it appears that it was given with judicious haste. Although it doesn't say *how much* fluid was given before surgery it may have prevented the cardiac arrest to have administered 1,000 to 1,500 cc. of the total of 2,500 cc. of whole blood given, before the operation began. There is current debate as whether to enter the abdomen 'stat' regardless of the shock situation and shut off the bleeding or whether to utilize the time honored formula of regaining some stationary situation in the vital signs, before operating.

"Case No. 721: The lack of motivation on the patient's part here, reiterates the previous statements. Although it isn't mentioned how strongly the physician insisted that the patient come to the emergency room it is the obligation of the doctor to emphasize the seriousness of such a history. Even though he didn't know the person's identity he probably could get some idea as to the responsiveness of the caller. All of the serious possibilities that may exist should be related to impress the individual. Beyond this the doctor has done his duty and has no control over the events.

"Once again these cases continue to point out the 'old saw,' *early diagnosis!* Getting to the patient before irreversible changes occur is the essence of good therapy; two cases were patient-delay and one was probably physician-delay. It is rather trite to keep saying 'keep a high index of suspicion of ectopic pregnancy.' A physician, however, should always include tubal or other ectopic pregnancy in his differential diagnosis dealing with any woman between puberty and menopausal ages who has infraumbilical distress. This is imperative regardless of history or physical findings. The final diagnosis of ectopic pregnancy when considered, is not difficult if a stepwise program of elimination is followed, e. g., 'diagnosis by exclusion.'

"Once the diagnosis of ectopic pregnancy is established *early,* specific surgical intervention should follow, without delay"!



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There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

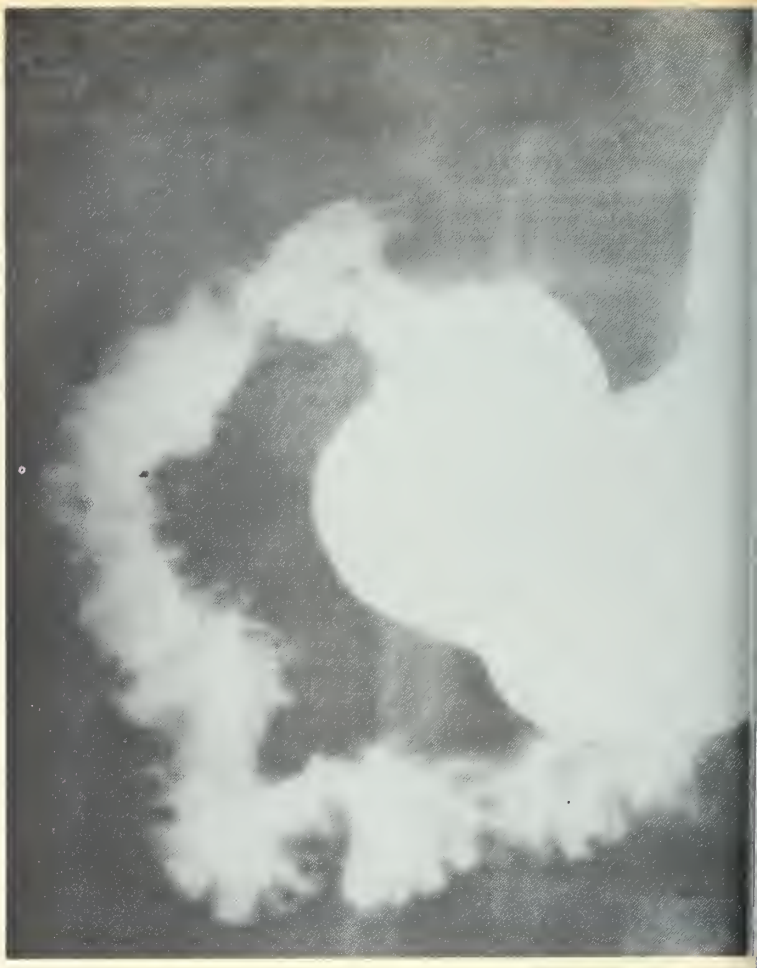
Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



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Conventional Radiography

The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive: Is this duodenum abnormal?



Hypotonic Duodenography

Pro-Banthine-induced duodenal calm permits full anatomic appraisal: Same patient. Duodenal normality is now evident.



• in diagnosis

• in treatment

Pro-Banthine® brand of propantheline bromide

calms the gastrointestinal tract

For fifteen years Pro-Banthine has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthine has reestablished its pharmacologic effectiveness in diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthine. The duodenum was intubated. Pro-Banthine in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

Contraindications: Glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27—Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

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NEWS AND Organization Section

Are You Eligible to Vote?...

Watch the March 27 Deadline, If You Must Register or Reregister to Vote in the May 7 Primary Elections

THIS is an all-important election year, and every citizen should determine that he is eligible to vote in the Primaries, or qualify himself before the March 27 registration deadline. Physicians in particular, as guardians of a professional heritage and as protectors of the public health, have an obligation in regard to elections — an obligation to help elect candidates worthy of the offices they seek. Every physician should determine that he, adult members of his family, and intimate friends are eligible to vote.

Here are qualifications for voting, excerpted from the "1968 Voter's Guide" issued from the Ohio Secretary of State's office:

You are Qualified to Vote if:

- You are a citizen of the U. S.
- You are at least 21 years of age or will be on the day of the next General Election (November 5, 1968).
- You have, at the time of the election, been a resident of: the state for one year; the county for 40 days; the voting precinct for 40 days. [If you have moved from one county to another county within Ohio, or from one precinct to another in the same county within 40 days before the election, you may vote in the precinct from which you moved.]
- You are registered. (This requirement applies only to persons who reside in registration territory.)

You must register to vote if:

You reside in registration territory. (Any city having a population of 16,000 or over, or any area which has adopted registration. Contact your county Board of Elections to determine your registration status.) Registration in Ohio is permanent, and need not be renewed unless:

- You have not voted at least once in the past two calendar years.
- You moved since you registered.
- You have changed your name. (A woman must reregister if she has married since she registered. If married after September 25, she may vote on November 5, but not thereafter, under her former name.)

If you have not voted in the past two calendar years, you have received, or will receive a notice and a form by which you may reregister by mail within thirty days after the date of the notice. If you have moved, you may reregister or change your address by mail on a form obtained from your County Board of Elections. If you have changed your name, you must reregister in person at the office of the County Board of Elections.

Persons who are members of the armed forces (and their spouses who are absent from Ohio for the purpose of being with or near them) need not be registered in order to vote while in service. Upon discharge, you must be registered if you reside in registration territory, excepting that if you are dis-

charged after September 25, you may vote by Armed Service Absent Voter Ballot at the office of the County Board of Elections if you make application by 12 o'clock noon of November 2, 1968.

Important Dates — Primary Election:

March 8 — Boards of Elections begin mailing Absent Voter Ballots to members of the armed services from whom applications have been received. Also first day for Boards of Elections to receive applications for Absent Voter Ballots by civilians outside the United States, and to begin mailing Absent Voter Ballots to civilians outside the United States.

March 27 — Last day to register.

April 7 — First day for Boards of Elections to receive applications for disabled and civilian absent voter ballots for persons located within the United States. Also first day of period during which votes may be cast at Boards of Elections by voters who expect to be absent from their counties and precincts on Election Day.

May 2 — Last day (ending at 4 P. M.) for voting at Boards of Elections by voters who will be absent from their counties and precincts on Election Day.

May 3 — By 12:00 NOON of this date civilian absent, sick, or disabled voter ballots must be delivered to clerks of Boards of Elections.

May 4 — By 12:00 NOON of this date applications for Armed Service Absent Voter Ballots must be received by clerks of Boards of Elections.

May 7 — Primary Election Day. Polls open at 6:30 A. M. and close at 6:30 P. M.

Ohioans Invited to Kentucky OB-Gyn Cancer Program

Ohio physicians have a special invitation to attend the Annual Spring Meeting of the Kentucky Obstetrical and Gynecological Society on Friday and Saturday, April 26 and 27. Meeting place is Stouffer's Louisville Inn, Louisville, Ky. The program starts at 9:00 A. M. on Friday, April 26, and concludes with a business meeting after lunch on Saturday.

The program is cosponsored by the Kentucky Division of the American Cancer Society. Registration should be made by April 1 with Walter M. Wolfe, M. D., Secretary-Treasurer, Louisville General Hospital, 323 East Chestnut Street, Louisville, Ky. 40202.

Among guest speakers will be the following:

Professor John Stallworthy, Professor of Obstetrics and Gynecology, Oxford University, U. K. England.

Howard W. Jones, M. D., Professor, Johns Hopkins School of Medicine, Baltimore, Maryland.

Richard Symmonds, M. D., Associate Professor, Department of Obstetrics and Gynecology, Mayo Graduate School of Medicine, Rochester, Minnesota.

Felix Rutledge, M. D., Chief Section Gynecology, M. D. Anderson Hospital, Houston, Texas.

Ohioans Are Now Serving on Various AMA Councils and Committees

At its meeting in November 1967, the Board of Trustees of the American Medical Association took action to appoint or reappoint members of its councils and committees. Included on the new roster are names of a number of Ohio physicians.

Term of service for members of councils and committees of the Board is one year with a maximum tenure of ten consecutive terms.

The following appointments and reappointments are of special interest in Ohio:

Dr. Wendell A. Butcher, Columbus, was reappointed to the Committee on Disaster Medical Care.

Dr. Robert E. Reiheld, Orrville, was reappointed to the Council on Rural Health.

Dr. Fay A. LeFevre, Cleveland, was reappointed to the Council on Scientific Assembly.

Dr. Paul L. Weygandt, Akron, was reappointed to the Committee on Medical Aspects of Automotive Safety.

Dr. Thomas E. Shaffer, Columbus, was reappointed to the Committee on Medical Aspects of Sports.

Dr. George W. Petznick, Cleveland, was reappointed as a physician member of the Committee on Medicine and Religion.

The Rev. Granger E. Westberg, Springfield, was reappointed to the Committee on Medicine and Religion as a member of the clergy.

Dr. Carl E. Wasmuth, Cleveland, was reappointed to the Committee on Medicolegal Problems.

Dr. John Budd, Cleveland, was appointed to the Committee on Planning and Development.

Dr. Dwight M. Palmer, Columbus, was reappointed to the Committee on Rating of Mental and Physical Impairment.

Dr. Nicholas DePiero, Garfield Heights, was named to the Interspecialty Committee as alternate for the American Society of Anesthesiologists.

Dr. Janet T. Dingle, Cleveland, was reappointed to the Committee on Human Reproduction.

A former Ohioan, Dr. John D. Porterfield, Chicago, now director of the Joint Commission on Accreditation of Hospitals, was reappointed to the Council on Environmental and Public Health. He was also reappointed to the Joint Committee on Environmental Health (AMA and American Institute of Architects).

Another former Ohioan, Dr. Charles L. Leedham, now of Harrisburg, Pa., was reappointed to the Council on National Security.

The "Annual Report — The Surgeon General, United States Army," for fiscal year 1966 has been distributed by the office of the Surgeon General. Compiled by the Historical Unit, U. S. Army Medical Service, the 140-page paperback volume was published by the U. S. Government Printing Office.

Family Practice Seminar . . .

Ohio Academy of General Practice and Cosponsors To Present Two-Day Comprehensive Program in Columbus on April 24-25

THE Ohio Academy of General Practice has announced its "Family Practice Seminar" to be held at Stouffer's University Inn, 3025 Olentangy River Road, Columbus, on Wednesday and Thursday, April 24 and 25. Registration begins on Wednesday at 8:00 A. M., with program features starting at 8:30 A. M.

The program has been announced as follows:

Wednesday Morning, April 24

Introductions: Tennyson Williams, M. D., Chairman, Medical School Family Practice Committee, Ohio Academy of General Practice;

B. L. Huffman, Jr., M. D., Toledo, President, OAGP.

Robert E. Howard, M. D., Cincinnati, President, Ohio State Medical Association.

Opening Statement: Arthur Nelson, M. D., Executive Director, Temple University Hospital, Philadelphia, Program Chairman.

The Crisis in Family Health Care — E. Grey Dimond, M. D., Scripps Clinic, La Jolla, Calif.

Education for Family Practice — 1968 (Panel) — Moderator — Vernon Wilson, M. D., Executive Director for Health Affairs, University of Missouri.

Undergraduate — Lynn Carmichael, M. D., Director, Division of Family Medicine, University of Miami Medical School.

Graduate — George Burkett, Jr., M. D., Kingman, Kansas, President, American Academy of General Practice.

Continuing Education — Joel Alpert, M. D., Medical Director, Family Health Care Program, Harvard University Medical School.

Group Discussion on Foregoing Topics.

Wednesday Afternoon

Family Practice in New England; An Evaluation— Whitney Brown, M. D., Needham, Mass., Harvard University, Boston.

The Abandoned Patient — Anne Somers, Princeton University.

Group Discussion on Foregoing Topics.

Thursday Morning, April 25

Education for Family Practice — Whose Responsibility? — Panel Moderator: Vernon Wilson, M. D., Executive Director for Health Affairs, University of Missouri.

The Role of Community Hospitals — Warren Harding, M. D., Medical Director, Grant Hospital, Columbus.

The Role of University Hospitals — Robert Haggerty, M. D., Chairman, Department of Pediatrics, University of Rochester School of Medicine.

The Role of Preceptorship — Nicholas Pisacano, M. D., Director of Medical Education, University of Kentucky.

Discussion Groups.

Thursday Afternoon

Reports from Leaders of Discussion Groups — Presiding: Thomas Rardin, M. D., Columbus, Chairman, Committee on Education, Ohio State Medical Association.

Past, Present, and Future — Dr. Wilson.

Adjournment of Seminar — Dr. Nelson.

What To Write For

What's New on Smoking in Print. A U. S. Public Health Service leaflet listing sources of new educational material. Also **What's New on Smoking in Films.** 5 cents each from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

In the Vital and Health Statistics series of the U. S. Public Health Service: **Family Hospital and Surgical Insurance Coverage — U. S., July 1962 - June 1963** — Series 10, No. 42 (30 cents); **Homicide in the United States, 1950-1964**—Series 20, No. 6 (30 cents); **Plan, Operation, and Response Results of a Program of Children's Examinations** (40 cents). For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

Members of the HOUSE OF DELEGATES

LISTED in the following columns are Delegates and Alternate Delegates to the OSMA House of Delegates, as reported from each county to represent their respective County Medical Societies at the 1968 OSMA Annual Meeting, May 13-17, at the Netherland Hilton Hotel and the Cincinnati-Exposition Center, Cincinnati.

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	Stevens, Francis L.	Young, Juan
BROWN	Donohoo, John R.	Pasquale, Andrew J.
BUTLER	Johnson, Robert P. Marr, G. E.	Fening, Clifford H. Glins, Richard J.
CLERMONT	Minning, Carl A.	
CLINTON	Terrell, Paul W.	Buchanan, Richard R.
HAMILTON	Cleveland, Frank P. Coith, Robert L. Crotty, Joseph G. Culbertson, William R. Hines, Harry K. Jones, Daniel V. Koehler, Carl W. Maurer, Elmer R. Nadler, Arthur W. Pfister, Howard F. C. Roof, Clyde S. Rubenstein, Eli Sebastian, Charles A. Simon, Stanley D. Thielen, Albert E. Woolford, Robert M.	Accetta, Goffredo S. Ahlering, William C. Brockmeier, Frederick Flessa, Herbert C. Frederick, Kenneth A. Heidt, Robert S. McClellan, Marvin Peck, Warner A., Jr. Pfister, Glenn W., Jr. Podesta, Joseph J. Selzer, Jack D. Spreen, Arthur Wulsin, John H.
HIGHLAND		
WARREN	Fox, Thomas E.	Layman, Orville L.
SECOND DISTRICT		
CHAMPAIGN	Miller, Isador	Frederick, Victor R.
CLARK	Rechsteiner, John W. Diederichs, Henry	Anton, Anthony T. Fralick, Charles E.
DARKE	Kane, Maurice M.	Browne, William A.
GREENE	Henderson, Roger C.	Vernier, Paul C.
MIAMI	Hammon, Jerry L.	Hudson, Dale A.
MONTGOMERY	Bruce, Robert A. Cassel, William G. Porter, William M. Shively, Franklin L., Jr. Tye, James G.	Brown, John R. Keys, John R. Muehlstein, John H. Taylor, John H. Worthman, John
PREBLE	Brian, Chester J.	Trittschuh, Everett P.
SHELBY	Schroer, William	Hunter, Thomas W.
THIRD DISTRICT		
ALLEN	Becker, Dwight L. Berlin, Fred P.	Glorioso, John A. Holladay, R. L.
AUGLAIZE	Oyer, Robert S.	Stienecker, C. D.
CRAWFORD	Newhard, Horace B.	Bibler, Darrel D.
HANCOCK	Brumley, Donald R.	
HARDIN	Johnson, Clarence L.	Zaring, Wendell I.
LOGAN	Browning, Charles A.	
MARION	Lyon, Paul E.	Mogg, Albert M.
MERCER	Otis, James J.	Fox, Donald R.
SENECA	Daniel, Walter A.	Sheeran, Emmet T.
VAN WERT		
WYANDOT	Smith, Donald P.	Garster, Richard L.

Counties	Delegates	Alternates
FOURTH DISTRICT		
DEFIANCE	Jaeckle, Charles E.	Diaz, Carlos R.
FULTON	Neal, William J.	Cotterman, Vernon L.
HENRY		
LUCAS	Bates, George N. Glow, Edmond F. Ockuly, Edward F. Osgood, Frederick P. Rawling, Frank F. A. Smith, Merl B.	Booth, George T. Kozy, John S. Sawyer, John B. Overstreet, P. A. Smith, H. E. Whitehead, Randolph P.
OTTAWA	Wood, Cyrus B.	Reeves, Robert S.
PAULDING	Farling, D. E.	Ward, D. P.
PUTNAM	Rice, Milo B.	Overmier, James B.
SANDUSKY	Borden, Robert A.	Rini, Anthony C.
WILLIAMS	Dilworth, Robert W.	Moats, J. E.
WOOD	Nyce, Clarence B.	
FIFTH DISTRICT		
ASHTABULA	Burroughs, Shepard A.	Macaulay, James G.
CUYAHOGA	Avellone, Joseph C. Boukalik, William F. Colombi, Christopher A. Crawford, Henry A. Dworken, Harvey J. Fishman, David Gaughan, John J. Grady, John J. Jablonoski, Chester R. Johnson, Herbert H. Kelly, Fred R. Kennedy, Roscoe J. LaMaida, Vincent. T. Lambright, M. H. Levy, Richard P. Mielcarek, Paul A. Petznick, George W. Sanders, John H. Schneider, A. B., Jr. Suppes, Frederick T. Trowbridge, William V. Van Ordstrand, H. S. Weckesser, Elden C.	Barker, Harold J. Campbell, Leland E. Coppedge, E. Peter Corrigan, Peter J. DePiero, Nicholas G. Eichner, Eduard Gifford, Ray W. Grau, Harry R. Hermann, Robert E. Huggins, Clarence L. Jobe, Charles H. Light, Frederick V. Linke, Thomas F. Longley, L. Philip McCormack, L. J. Menges, Hermann, Jr. Schneider, David H. Stephens, Timothy L. Williams, Robert F. Wolkin, Julius
GEAUGA	Behm, Alton W.	Andreas, Bruce F.
LAKE	Irvin, Robert A. Pignolet, W. J.	Burnham, Maxwell E. Killian, Harry A.
SIXTH DISTRICT		
COLUMBIANA	Banfield, William S.	Pritchard, Leonard S.
MAHONING	Caccamo, Leonard P. DeCicco, G. E. Newsome, J. V. Schreiber, Jack	Buckley, J. J. Friedrich, Frederick A. Loeser, William D. Saadi, E. T.
PORTAGE	Palmstrom, David	Sprogis, George R.
STARK	Ahbel, Andreas S. Grable, E. E. Herbst, Mark G. Lieber, Maurice F.	Bucur, John Musgrave, Myrle D. Skibbens, Richard V. Underwood, Lee C.
SUMMIT	Champion, Richard H. Evans, Douglas Jackson, Thomas W. Werner, Marshall R. Yeakley Robert E.	Frye, Paul E. Mathias, D. W. Thompson, Robert E.
TRUMBULL	Pollis, Steven A. Whiteman, Rex K.	Paul, Robert Phillips, John
SEVENTH DISTRICT		
BELMONT	Arbaugh, E. V., Jr.	Phillips, Richard B.
CARROLL	Lincke, Carl A.	Dowell, G. C.
COSHOCTON	Johnson, Robert R.	Wright, Norman L.
HARRISON	Trupovnieks, Janis	Evans, Charles D.
JEFFERSON	Strovilas, Crist G.	Mastros, Paul
MONROE	Gillespie, Byron	
TUSCARAWAS	Rinderknecht, R. E.	Hudson, William E.

(Continued on Next Page)

Counties	Delegates	Alternates
EIGHTH DISTRICT		
ATHENS	Kinnard, Philip	Whanger, Herbert N.
FAIRFIELD	Kraker, Jack L.	Swett, Chester P.
GUERNSEY	Toland, J. A. L.	Ringer, Robert A.
LICKING	Kennedy, J. H.	Karaffa, Frederick N.
MORGAN	Coulson, A. A.	Bachman, Henry
MUSKINGUM	Spragg, Carl E.	Smith, W. B.
NOBLE	Ditch, Edward G.	Cox, Frederick M.
PERRY	Herendeen, Ralph, Jr.	Bope, Charles E.
WASHINGTON	Bennett, Kenneth E.	Eddy, Ford E.
NINTH DISTRICT		
GALLIA	Morgan, Thomas W.	Thomas, Homer B.
HOCKING	Matthews, Jan S.	
JACKSON	Fitzpatrick, Clarence C.	MacLennan, John C.
LAWRENCE	Payne, A. Justin	Geswein, Gerard C.
MEIGS	Daniels, Roger P.	
PIKE	Shrader, Albert M.	Wilkinson, Kenneth
SCIOTO	Allen, Chester H.	Gaspich, Keith
VINTON	Bullock, Richard E.	
TENTH DISTRICT		
DELAWARE	Callander, Adelbert R.	Williams, Tennyson
FAYETTE	Heiny, Robert A.	Hancock, Thomas J.
FRANKLIN	Anthony, Michael A.	Baker, Norman H.
	Bonta, Joseph A.	Barnes, Lloyd W.
	Dickens, Dale R.	Good, James C.
	Hunt, William E.	Heilman, Robert A.
	Lewis, Tom F.	Meyer, Thomas L.
	Pavey, Charles W.	Millhon, Judson S.
	Porterfield, H. William	Philips, Vol K.
	Tetirick, Jack E.	Pollack, Alexander
	Traphagen, D. W.	Smith, William P., Jr.
KNOX	McLarnan, James C.	Lapp, Henry T.
MADISON	Starr, John C.	Maggied, Sol
MORROW	Ingmire, Joseph P.	Hickson, David James
PICKAWAY	Hedges, Jasper M.	Smith, Robert G.
ROSS	Coppel, Lewis W.	McCarter, Paul, Jr.
UNION	Zaugg, Paul R.	Hurl, Rodney B.
ELEVENTH DISTRICT		
ASHLAND	Shilling, Myrle D.	McMullen, Charles H.
ERIE	Meckstroth, Emil J.	Gillette, Robert D.
HOLMES	Earney, Adam J.	Patterson, Owen F.
HURON	Graham, William R.	McLoney, Earl R.
LORAIN	Myers, Ben V.	Durfee, Max L.
	Stephens, James T.	Miller, William H.
MEDINA	Avery, Richard W.	Halley, William G.
RICHLAND	Bell, Wendell M.	Brody, Stanley L.
	Quick, Carl M.	Shamess, C. J.
WAYNE	Huff, Albert B.	Robinson, John M.

OFFICERS

Pres.	Robert E. Howard	Past Pres.	L. C. Meredith
Pres.-Elect	Theodore L. Light	Treas.	James L. Henry

COUNCILORS

District		District	
First	Paul N. Ivins	Seventh	Sanford Press
Second	George J. Schroer	Eighth	William M. Wells
Third	Frederick T. Merchant	Ninth	Oscar W. Clarke
Fourth	Robert N. Smith	Tenth	Richard L. Fulton
Fifth	P. John Robechek	Eleventh	William R. Schultz
Sixth	Edwin R. Westbrook		

Deadline for Submission of Resolutions to Columbus Office of the Association Is March 14

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1968 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal,* must be introduced at the first session of the House of Delegates, Monday evening, May 13, at the Netherland-Hilton Hotel, Cincinnati.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 14. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

HOUSE OF DELEGATES

MONDAY, MAY 13

4:00 P. M.

Netherland Hilton Hotel

Councilor District Caucuses

District	Councilor	Suite Number
First	Paul N. Ivins	930 - 932
Second	George J. Schroer	1602 - 1604
Third	Frederick T. Merchant	1702 - 1704
Fourth	Robert N. Smith	1030 - 1032
Fifth	P. John Robechek	1230 - 1232
Sixth	Edwin R. Westbrook	1430 - 1432
Seventh	Sanford Press	1802 - 1804
Eighth	William M. Wells	1902 - 1904
Ninth	Oscar W. Clarke	2002 - 2004
Tenth	Richard L. Fulton	1130 - 1132
Eleventh	William R. Schultz	2102 - 2104

MONDAY, MAY 13

5:00 P. M.

Registration for OSMA House of Delegates
Third Floor Foyer
Netherland Hilton Hotel

5:30 P. M.

Buffet Dinner for Delegates, Alternates,
OSMA Council, and Official Guests
Pavillon Caprice, Fourth Floor
Netherland Hilton Hotel

7:00 P. M.

OSMA House of Delegates, First Business Session
Hall of Mirrors, Third Floor
Netherland Hilton Hotel

Invocation — The Reverend Roger B. Rollins, St. Andrew's Episcopal Church, Dayton.

Welcome by Stanley D. Simon, M. D., Cincinnati, President, Cincinnati Academy of Medicine.

Introduction of the President, Robert E. Howard, M. D., Cincinnati.

Consideration of the Minutes of the last Annual Meeting (July, 1967 issue of *The Journal*).

Introduction of honored guests.

Report by the President of the Woman's Auxiliary — Mrs. J. Paul Sauvageot, Akron.

Presentation of AMA-ERF checks to representatives of the University of Cincinnati College of Medicine; Western Reserve University School of Medicine; and Ohio State University College of Medicine — Robert S. Martin, M. D., Chairman, Ohio Committee on AMA-ERF.

Presentation of plaques honoring physicians serving with Project Viet Nam — Robert E. Howard, M. D., Cincinnati, OSMA President.

Presentation of plaques to past Councilors.

Appointment of Reference Committees by the President:
Credentials
President's Address
Resolutions
Tellers and Judges of Election

Nomination and election of Committee on Nominations:
(Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Thursday, May 16, 7:30 P. M., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Sixth District shall serve as chairman.)

Introduction of Resolutions:
(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Thursday evening session before any action can be taken. All resolutions not submitted in advance of the 60-day deadline must be typewritten and submitted in triplicate.)

Announcement of meeting places of Reference Committees.

Miscellaneous business.

Announcement of Annual Meeting events.

Recess.

TUESDAY, MAY 14

9:00 A. M.

MEETINGS OF REFERENCE COMMITTEES

Resolutions Committee No. 1 —
Room 215, Cincinnati-Exposition Center

Resolutions Committee No. 2 —
Room 219, Cincinnati-Exposition Center

Resolutions Committee No. 3 —
Room 217, Cincinnati-Exposition Center

(Continued on Next Page)

Committee on Nominations —
Room 221, Cincinnati-Exposition Center

Committee on President's Address —
Room 223, Cincinnati-Exposition Center

(Note: If necessary, the Reference Committees will meet in the same rooms, Tuesday, May 14, at 1:30 P. M.)

THURSDAY, MAY 16
HOUSE OF DELEGATES

5:30 P. M.

German Smorgasbord for Delegates, Alternates, OSMA Council, Official Guests, and Exhibitors
Pavillon Caprice, Fourth Floor
Netherland Hilton Hotel

6:00 P. M.

OSMA House of Delegates Registration
Third Floor Foyer
Netherland Hilton Hotel

7:30 P. M.

OSMA House of Delegates, Final Business Session
Hall of Mirrors, Third Floor
Netherland Hilton Hotel

Introduction of honored guests.

Remarks by Mrs. Karl Ritter, Lima, President, Woman's Auxiliary to the American Medical Association

Consideration of unfinished business.

Reports of Reference Committees:
President's Address
Resolutions

Election of President-Elect.

Report of Committee on Nominations.

(a) Nominations for The Council.
(Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years.) To be elected:

First District — (Incumbent, Paul N. Ivins, M. D., Hamilton.)

Third District — (Incumbent, Frederick T. Merchant, M. D., Marion.)

Fifth District — (Incumbent, P. John Robechek, M. D., Cleveland.)

Seventh District — (Incumbent, Sanford Press, M. D., Steubenville.)

Eighth District — (Incumbent, William M. Wells, M. D., Newark). Note: Dr. Wells was appointed by The Council to succeed James A. Quinn, Jr., M. D., Newark, who moved to Oklahoma in September. The OSMA Constitution and Bylaws provides that a Councilor appointed in this manner will serve until the next election. The election will be for the one-year, unexpired term.

Ninth District — (Incumbent, Oscar W. Clarke, M. D., Gallipolis.)

Eleventh District — (Incumbent, William R. Schultz, M. D., Wooster.)

(b) Election of Delegates and Alternates to the American Medical Association — 4 Delegates and 4 Alternates to be elected, each for a two-year term starting January 1, 1969, in compliance with the Constitution and Bylaws of the American Medical Association.

AMA Delegates and Alternates seeking election and re-election at the OSMA Annual Meeting in May, will run at large for the four delegate and alternate openings available. To be valid, a ballot shall contain as many names as offices contested and the first four candidates to receive a majority of all votes cast shall be declared elected.

If no nominee receives a majority of votes cast on a ballot, the nominee with lowest number of votes shall be dropped and a new ballot taken. Nominees receiving a majority of votes cast shall be declared elected, will have their names dropped from further balloting, and voting will continue until the remaining offices are filled by majority votes.

The following incumbent Delegates and Alternates will serve for the remainder of 1968 and they may be considered by the nominating committee:

Delegates	Alternates
Geo. W. Petznick, M. D. Cleveland	Horatio T. Pease, M. D. Wadsworth
Carl A. Lincke M. D. Carrollton	Robert S. Martin, M. D. Zanesville
T. L. Light, M. D. Dayton	Kenneth D. Arn, M. D. Dayton
Edmond K. Yantes, M. D. Wilmington	Harry K. Hines, M. D. Cincinnati
Robert E. Tschantz, M. D. Canton	Henry A. Crawford, M. D. Cleveland

Installation of Officers for 1968-1969.

Submission of committee appointments by the new President for confirmation by the House of Delegates.

Unfinished or new business.

Adjournment.

OHIO STATE MEDICAL ASSOCIATION
ANNUAL MEETING



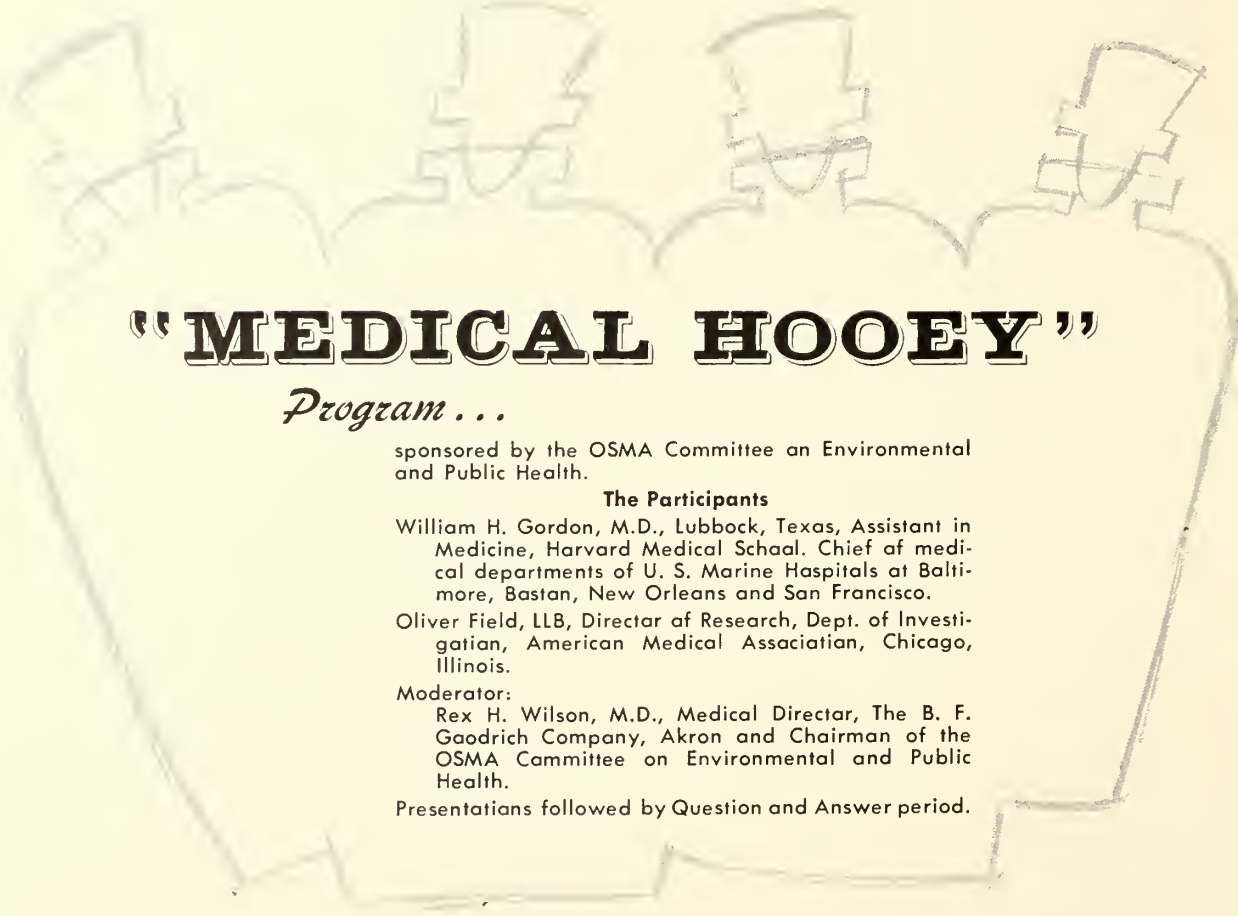
GENERAL SESSION

TUESDAY, MAY 14

1:00 P.M.

ROOM NO. 209

Cincinnati-Exposition Center



"MEDICAL HOOEY"

Program . . .

sponsored by the OSMA Committee an Environmental and Public Health.

The Participants

William H. Gordon, M.D., Lubbock, Texas, Assistant in Medicine, Harvard Medical Schaal. Chief af medical departments of U. S. Marine Haspitals at Baltimore, Bastan, New Orleans and San Francisco.

Oliver Field, LLB, Directar af Research, Dept. of Investigatian, American Medical Assaciatian, Chicago, Illinois.

Moderator:
Rex H. Wilson, M.D., Medical Directar, The B. F. Gaodrich Company, Akron and Chairman of the OSMA Committee on Environmental and Public Health.

Presentatians followed by Question and Answer period.



elp clear up that miserable stuffed-up eling with Dimetapp. Each hard-work- g Extentab brings welcome relief from e stuffiness, drip and congestion of upper spiratory conditions for up to 10-12 ours. Yet, patients seldom experience owsiness or overstimulation. The key to ccess is the Dimetapp formula: Dime- ne (brompheniramine maleate)—along th phenylephrine and phenylpropanola- ine, two time-tested decongestants. They t the job done . . . in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

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and

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In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

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Social Highlights

1968 OSMA Annual Meeting

A NUMBER of the Specialty Societies and allied groups meeting in conjunction with the Ohio State Medical Association in Cincinnati, May 13-17 have planned reunions, get-togethers, breakfasts, luncheons, etc. In order that you may mark your calendar now, we are listing below those activities which the OSMA office has received prior to press time of this *Journal* issue. The Woman's Auxiliary program may be found on page 358 and the Health Commissioners' Institute program on page 361. See OSMA House of Delegates functions on page 352.

TUESDAY, MAY 14

OHIO HEALTH COMMISSIONERS INSTITUTE Banquet: 6:00 P. M. social hour followed by banquet at 7:00 P. M. in Parlors A, B, C, and D of the Netherland Hilton, Hotel, Fourth Floor.

CASE WESTERN RESERVE UNIVERSITY Medical Alumni Reunion: 6:00 P. M. cocktail party and reunion of alumni in Parlors E and F of the Netherland Hilton Hotel, Fourth Floor.

OPHTHALMOLOGY SECTION, Ohio Ophthalmological Society and the Cincinnati Society of Ophthalmology: Joint dinner meeting, 7:00 P. M., Academy of Medicine of Cincinnati, 320 Broadway, Cincinnati.

EAR, NOSE, AND THROAT SECTION and Ohio Ear, Nose, and Throat Society: A reception for members, guests, and wives will be held in Parlor G of the Netherland Hilton Hotel beginning at 7:00 P. M.

OHIO DELEGATION TO THE American Medical Association: 9:30 P. M., Parlor H, Fourth Floor, Netherland Hilton Hotel.

AMERICAN MEDICAL WOMEN'S ASSOCIATION (Branch 11) Hospitality Parlor: Room 227, Cincinnati - Exposition Center. Hours open — Tuesday, May 14, NOON until Friday NOON, May 17, during regular exhibit hours.

WEDNESDAY, MAY 15

OHIO OPHTHALMOLOGICAL SOCIETY Luncheon: 12:00 NOON, Room 219, Cincinnati-Exposition Center.

GASLIGHT PARTY: 7:00 P. M., Pavillon Caprice, Fourth Floor, Netherland Hilton Hotel. Tickets for sale in advance, see coupon on page 359, $8.00 per person. Invite your colleagues, come prepared for an evening of fun.

THURSDAY, MAY 16

OMPAC BOARD Breakfast: 8:00 A. M., Parlor D, Fourth Floor, Netherland Hilton Hotel followed by business meeting of board.

OHIO COMMITTEE ON TRAUMA, American College of Surgeons Breakfast: 8:30 A. M., Parlors A, B, and C, Fourth Floor, Netherland Hilton Hotel.

OMPAC LUNCHEON: 11:30 A. M., Room 210, Cincinnati-Exposition Center, cocktails followed by luncheon. Congressman Robert Taft, Jr., will be guest speaker. Tickets for sale in advance, see coupon on page 359, $5.00 per person.

OHIO SOCIETY OF INTERNAL MEDICINE Board of Trustees Luncheon: 12:00 NOON, Parlor E, Fourth Floor, Netherland Hilton Hotel.

JEFFERSON MEDICAL COLLEGE ALUMNI Association: Open house, 5:30 P. M., Parlors A, B, and C, Fourth Floor, Netherland Hilton Hotel.

FRIDAY, MAY 17

NEUROLOGICAL SURGERY SECTION, Ohio State Neurosurgical Society Luncheon: 12:00 NOON, Pigall's French Restaurant, Inc., 127 W. Fourth St.

OHIO ORTHOPAEDIC SOCIETY: 6:00 P. M., cocktails, and banquet, Holiday Inn Downtown, Cincinnati, Banquet Room A.

NEUROLOGICAL SURGERY SECTION, Ohio State Neurosurgical Society: Social hour 7:00 P. M. followed by dinner at 8:00 P. M. at the Maisonette Restaurant, 114 East Sixth St.

Twenty-Eighth Annual Convention

of the

Woman's Auxiliary to the Ohio State Medical Association

May 13 - 16 Headquarters — Terrace Hilton Hotel

MONDAY, MAY 13

8:30 P. M. — Budget and Finance Committee
(President's Suite, Terrace Hilton)

TUESDAY, MAY 14

10:00 A. M. - 4:00 P. M. — Registration
(Foyer, Terrace Hilton)

10:00 A. M. — Resolutions Committee
(A Corner Suite, Terrace Hilton)

12:00 NOON — State Board Luncheon
(Ohio Room, Terrace Hilton)

1:00 P. M. — State Board Preconvention Meeting
(Ohio Room, Terrace Hilton)

7:00 - 10:30 P. M. — Boatride and dinner on the "S. S. Jubilee"

WEDNESDAY, MAY 15

8:00 A. M. - 4:00 P. M. — Registration
(Foyer, Terrace Hilton)

8:00 A. M. - 4:00 P. M. — Hospitality Room and Crafts Exhibit
(Ohio-Valley Room, Terrace Hilton)

9:00 A. M. - 5:00 P. M. — Displays
(Cincinnati Exposition Center)

9:00 - 11:30 A. M. — First Business Session
(Ball Room, Terrace Hilton)

11:45 A. M. - 1:15 P. M. — "Americana" Luncheon —Honoring Mrs. Karl F. Ritter, President of the Woman's Auxiliary to the AMA, and Edward R. Annis, M. D., Past President of the AMA
(Pavillon Caprice-Netherland Hilton Hotel)

1:30 P. M. — General Session of the OSMA — "Medicare Plus Two Years — How Is the Medical Profession Faring?" — Featuring Edward R. Annis, M. D., Past President of the AMA
(Cincinnati Exposition Center—Room 209)

2:30 - 5:30 P. M. — Voting
(Parlor A, Terrace Hilton)

3:00 - 5:00 P. M. — "Scenes and Schemes of the County Auxiliaries and AMPAC - OMPAC" — Featuring County Auxiliary Presidents and AMPAC Representative
(Ball Room, Terrace Hilton)

7:00 P. M. — Gaslight Party — OSMA
(Pavillon Caprice, Netherland Hilton)

THURSDAY, MAY 16

7:30 - 8:30 A. M.—"French Country Breakfast" featuring "Chef Gregory" Honoring County Presidents, Past State Presidents and National Guests
(Ball Room, Terrace Hilton)

8:00 - 10:00 A. M. — Registration
(Foyer, Terrace Hilton)

8:00 - 10:00 A. M. — Hospitality Room and Crafts Exhibit
(Ohio Valley Room, Terrace Hilton)

9:00 A. M. - 5:00 P. M. — Displays
(Cincinnati Exposition Hall)

9:00 - 11:00 A. M. — Second Business Session
(Ball Room, Terrace Hilton)

11:15 A. M. — Reception — Honoring New Board
(Ohio-Valley Room, Terrace Hilton)

12:00 NOON — OMPAC Luncheon, Speaker: Congressman Robert A. Taft, Jr.
(Cincinnati Exposition Center—Room 210)

1:30 P. M. — Post Convention Board Meeting
(Ohio Room, Terrace Hilton)

GASLIGHT PARTY

WEDNESDAY, MAY 15, 1968

NETHERLAND-HILTON HOTEL, CINCINNATI

(Pavillon Caprice, Fourth Floor)



Send your reservation in NOW! Come prepared for a real evening of Fun!

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OMPAC
LUNCHEON

Enclosed is $_____ to pay for:

_____ Tickets to Gaslight Party ($8.00 per person)

_____ Tickets to OMPAC Luncheon ($5.00 per person)

Wednesday, May 15
Netherland Hilton Hotel
7:00 P.M.
Featuring Chicago's
GASLIGHT ROADSHOW

Thursday, May 16
Cincinnati-Exposition Center
11:30 A.M.
Featuring Congressman
ROBERT TAFT, JR.

Please make checks payable to: **THE OHIO STATE MEDICAL ASSOCIATION**

Fun!

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Name:_____

Street Address:_____

City and State:_____

GENERAL SESSION
FRIDAY, MAY 17, 1968
9:00 A.M.



ROOM NO. 209
Cincinnati
Exposition
Center

Featuring . . .

Fronk J. Ayd, Jr., M.D., Boltimore, Morylond

Helen I. Glueck, M.D., Cincinnoti General Hospital

Rabbi Robert L. Kotz, Cincinnoti, Professor of Humon Relations, Hebrew University College

Rev. L. H. Moyfield, Choplain, Christ Hospitol, Cincinnati

The Rev. Fother Donold McCorthy, Cincinnati, Associote Professor of Philosophy, Mt. St. Morys Seminary

Rev. Dr. Poul B. McCleove, Director, Dept. of Medicine ond Religion, Americon Medicol Associotion, Chicogo, Illinois

Edword T. Tyler, M.D., Los Angeles, Colifornia, Clinical Professor of Medicine, Obstetrics ond Gynecology, UCLA School of Medicine

Panel Program sponsored by the OSMA Committee on Medicine ond Religion.

Ohio Health Commissioners' Institute, Cincinnati

May 14, 15, and 16

In Conjunction with OSMA Annual Meeting

All meetings, except social functions, Room 225, Cincinnati-Exposition Center

TUESDAY, MAY 14

11:00 A. M. — Meeting with Director of Health E. W. Arnold, M. D.

12:00 NOON — Lunch

1:00 P. M. — What's New: Mumps, Vaccine, Paul F. Wehrle, M. D., Los Angeles, California

2:00 P. M. — What's Going On! — 20 Minute Quickies — Cervical Cancer Detection

2:30 P. M. — Break

3:00 P. M. — What's Going On! (Continued)

3:00 P. M. — Fluoridation

3:30 P. M. — Family Planning

4:00 P. M. — Communicative Disorders

4:30 P. M. — Adjournment

6:00 P. M. — Social Hour
(Netherland Hilton Hotel—Parlors A, B, C, D)

7:00 P. M. — Health Commissioners' Banquet

WEDNESDAY, MAY 15

9:00 A. M. — OSMA General Session — Sponsored by: Ohio Division, American Cancer Society Research: Virus, Albert Sabin, M. D.

10:30 A. M. — Break

11:00 A. M. — Comprehensive Health Planning — Sewall Milliken, Chief, Office of Comprehensive Health Planning, Ohio Department of Health

12:00 NOON — Lunch

1:00 P. M. — Environmental Health — John A. Logan, D. Sc., Rose Polytechnic Institute, Terre Haute, Indiana

2:30 P. M. — Break

3:00 P. M. — Environmental Health (Continued) Bureau of Environmental Health, Ohio Department of Health

7:00 P. M. — OSMA Gaslight Party
(Pavillon Caprice Netherland Hilton Hotel)



John A. Logan, D. Sc.

Educator, private practitioner in the civil engineering field, governmental consultant, and world traveler on environmental health assignments, Dr. Logan is prepared to present interesting discussions on the development of a rational approach to the conservation and control of man's environment, especially in regard to disease prevention. He will be principal speaker on the Wednesday afternoon, May 15, program of the Ohio Health Commissioners' Institute.

THURSDAY, MAY 16

9:00 A. M. — Comprehensive Home Care Services

10:30 A. M. — Break to Tour Exhibits

11:00 A. M. — Emergency Health Services — Highway Safety

12:00 NOON — Lunch

1:30 P. M. — OSMA General Session — Emergency Room Problems — Panel Discussion

2:30 P. M. — Health Commissioners' Institute Adjourns

Leading Downtown Cincinnati Hotels
and Prevailing Rates

NETHERLAND HILTON HOTEL
5th and Race St.
Phone 621-3800
(OSMA Headquarters)

Singles ..... $10.50-$20.00
Doubles ..... $14.50-$18.00
Twins ..... $17.00-$25.00

TERRACE HILTON HOTEL
15 West 6th St.
Phone 381-4000
(Woman's Auxiliary Headquarters)

Singles $14.25
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SHERATON-GIBSON HOTEL
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FOR THE

1968 OSMA ANNUAL MEETING

Cincinnati May 13-17

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to change

If you plan to share a room,
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roommate.



HOTEL RESERVATION BLANK
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(Name of Hotel)

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(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 13-17 (or for period indicated)

_____ Single Room

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Other accommodations_____

Price Range_____

Arriving May_____ at _____A.M. _____P.M.

PLEASE VERIFY MY RESERVATION

NAME_____

ADDRESS_____

_____

Medical Ethics and Reasonable Fees

By GEORGE W. PETZNICK, M.D.*

ETHICS is a word that does not excite the interest of many people and, along with morality, is at once a broad and loose term in this free-wheeling society. However —

Medical ethics definitely provides that the charging of excessive fees is unethical!

If you are not concerned you should be as are your representatives in the House of Delegates of the American Medical Association who, in a series of far-reaching actions, voted proposals designed to come to grips with the escalating costs of medical care.

Why?

Because your AMA leaders realize that rising medical costs have recently become an issue of national importance — not only to politicians, labor leaders, and insurance carriers — but to the average American citizen who is paying the bills.

Along with the problems of increased costs of medical care are attempts to "impose standards of medical care on a national level."

For those of you who have missed the impact of that statement, let me suggest that a physician in court could have his medical care measured by the national standard of that care.

The Ethics of It

You may ask, What has this to do with medical ethics?

Ethics is a continuing search for principles by but this should not be distressing because the age in which we live is proof enough that there can be no simple answers to complex questions.

Ethics is a continuing search for principles by which "choice" can be guided. Choice is the important word.

It is a system of values based on truth and good.

In nearly every act of our respective lives, we are confronted with choices involving two or more alternatives. Many choices we must make are absurdly simple and some are astonishingly difficult.

If there is no choice to be made, then there is no problem. If there is only one course possible, the uncertainity of choice is removed and we follow that course.

If, by law, the government enacts standards of medical care and a fixed fee or salary for that care, you have but one choice — not yours but the governments.

John B. Archer, M. D., in a discussion of morality in medicine wrote that, in choosing, we exercise as many as four types of judgments.

The first and most important is moral judgment that distinguishes between right and wrong, good or bad.

Aesthetic judgment classifies objects and acts as beautiful or ugly.

Prudential judgment should tell us the difference between that which is wise and that which is foolish.

Logical judgment deals with the validity of fallacy of those things by which we would prove our positions.

Our judgment is never better than our information. To make informed judgments, we must possess the necessary knowledge and the ability to use it.

This we call wisdom!

Judicial Application

Is it wisdom to say that a medical society review committee must use its best professional judgment in determining the reasonableness of a fee? Emphatically the answer is "yes" because, if medicine is expected to succeed in achieving a usual, customary, and reasonable fee payment program involving all third parties, private, commercial, public, or government, then medicine must expect to assume the responsibility to assure the patient that the fee is usual, customary, and reasonable.

If medicine declines this responsibility or refuses to carry it out, the only alternative is for a lay third party to dictate fees. The privilege of the usual, customary, and reasonable fee for physicians carries with it the equal responsibility the profession must shoulder in determining reasonableness.

If medicine is to continue to be master of its own house, then it must accept and carry out this responsibility.

The fact that a physician consistly charges and collects an excessive fee for a particular procedure does not mean that this fee meets the usual customary, and reasonable criteria.

For example, a physician cannot ethically and logically argue that the fact that he charges all patients

*Dr. Petznick, a Cleveland practitioner, is a member of the American Medical Association Judicial Council, a Past President of the Ohio State Medical Association, and a Delegate to the AMA. This article is the text of a lecture prepared for delivery before the Conference of County Medical Society Officers, Columbus, February 25, 1968.

$500 for an appendectomy or $1000 for a laminectomy means that this is a reasonable fee.

Let me cite an actual bill from an Ohio allergist—

9-1-67	Consultation	$125.00
9-1-67	Allergy Tests	$125.00
9-3-67	Allergy Tests	$125.00
9-5-67	Allergy Tests	$125.00
	Total	$500

Let me quote from Sylvia Porter's nationally syndicated article of December 12, 1967. "One New York surgeon charged an elderly patient $175 to remove a cataract before medicare. But the same surgeon's charge for a similar operation on the same patient after medicare became effective was $500. Because of the deductibles and because the reasonable and customary fee allowed by the government for this operation was only a fraction of $500, this patient now had to pay $400 for the post medicare operation, instead of the $175 he paid pre-medicare.

A Look from the Inside

The excesses of a greedy fringe are openly and widely admitted. If the U. S. medical profession fails to curb them on its own, it will only be inviting further government controls on medical practice and fees, a step the profession wants least."

Doctors reportedly have increased their fees because they were told or knew that insurance would quite likely pay the bill. This is strange reasoning when it is realized that the physician raises his fee for services to a man who has been so concerned about paying his doctor when necessary that he has been saving his money for that purpose.

It isn't just a case of considering the ability of the patient to pay. Rather, consideration should be given to the fact that the individual has actually saved his money for this purpose, thus lessening to some extent the doctor's financial problem.

Providers of professional services are not only qualified but they are sanctioned in their endeavors by their fellow men. Logically, these professional people must impose additional limitations upon themselves with respect to this privilege and responsibility.

We call these additional and voluntarily assumed limitations a system of professional ethics.

The Principles of Medical Ethics of the *AMA* in the fewest possible words exhorts the physician to dedication, honesty, competence, responsibility, moral attainment, and good citizenship.

There is no reference, direct or indirect, to professional freedom. It is not a law, yet the whole of the document is a declaration of moral freedom, but only freedom to choose the right.

We are dealing with guides, admonitions, injunctions and moral yardsticks.

It has been observed that the greatest strength of any profession is within itself because it alone has the responsibility of its perpetuation, it alone has the responsibility for the extension of its knowledge, and it alone for the scope of its services.

The nature and characteristics of medicine being what they are, it is obvious that the profession contains the seeds of its own destruction.

If we nurture or even condone the incompetent, the morally deficient, or the willful violator, then we are helping these seeds to germinate.

Just as it is right and ethical for a physican to expect to receive his usual, customary, and reasonable fee for professional services, it is equally right and ethical, as stated by the AMA House of Delegates, that his fee may be reviewed only by a duly constituted county medical society committee of the physician's peers.

Most physicians charge reasonable fees.

Reflections on the Profession

County medical society review committees, ethics committees, grievance committees, or county medical societies as a whole, cannot continue to tolerate excessive charges by a few physicians, for these excesses cast improper, unwanted, and unethical reflections on the entire profession.

If medicine is to continue to be master of its own house, then it must accept and carry out this responsibility. If medicine fails, the course will lead the profession to prevailing fees, then to fixed fees, then to salaried employees of the government.

Is the profession worth so little to physicians that they will not effectively act against a very small minority to protect the character, reputation, freedom, and independence of the vast majority of doctors?

Medicine must wake up to the fact that there are many socio-political-government interests that are very anxious to control medicine and they know the easiest way to do this is to control fees.

Medical societies must be more aggressive and more effective in acting against excessive charges. The society must judge the act itself and not the stature or influence of the physician responsible for the act.

Finally, the *Principles of Medical Ethics* is the greatest professional code ever written, but it is not worth a nickel if the profession does not actively and effectively enforce the code.



"The inconvenience of a cold"

a cold, NTz® Nasal Spray provides rapid relief of l symptoms. Relief starts with the first spray which s the inferior part of the common meatus. A second /, a few minutes later, will shrink the turbinates to provide sinus drainage and ventilation. Dosage be repeated every three or four hours as needed, emporary relief of symptoms. NTz is well tolerated verdosage should be avoided.

sinusitis deterrent, NTz Nasal Spray can be used to the nasal passages open during a cold to help pre- development of acute sinusitis—or to help prevent cute condition from becoming chronic.

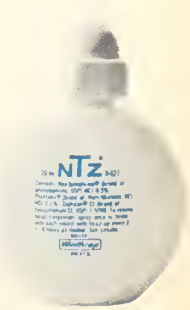
lied: NTz Nasal Spray, plastic squeeze bottles of l.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



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Valium® (diazepam)
useful adjunct for the coronary patient...

When oppressive feelings and psychic tensions are severe and cooperation with the physician poor, it may be helpful to add adjunctive Valium (diazepam), 10 mg or 5 mg t.i.d., to the coronary patient's regimen. Valium (diazepam) helps to promote the needed relaxation that the patient requires to make him less preoccupied with his condition and more inclined to cooperate in, and benefit from, the total therapeutic program. Valium (diazepam) may be administered in the presence of secondary depressive symptoms.

in the hospital...
(5 mg – or 10 mg t.i.d.)

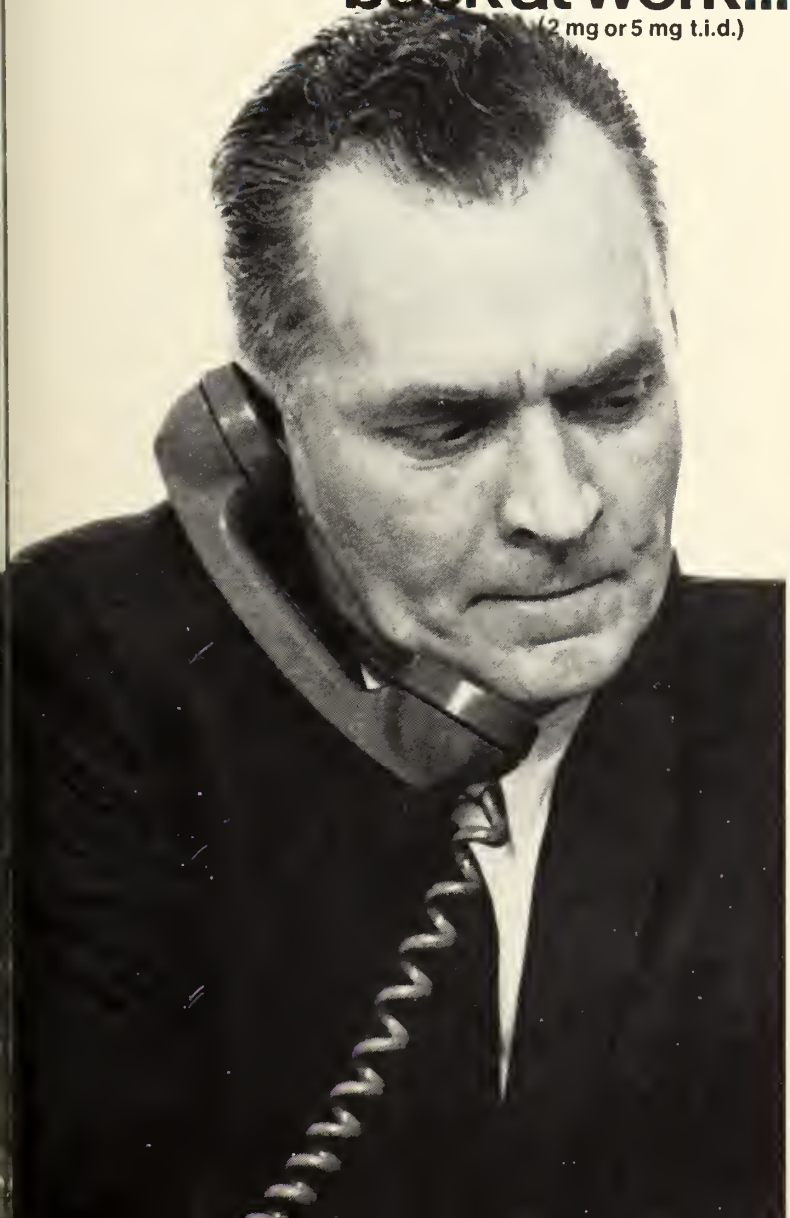


convalescing...
(2 mg or 5 mg t.i.d.)

The heart patient who leaves the hospital to enter a period of slow restorative treatment is often forced to make emotionally difficult adjustments. The resulting stress of this period may again cause psychic tension to mount to potentially harmful levels. To augment your reassurance and the emotional support of his family, a 2 mg or 5 mg t.i.d. regimen of Valium (diazepam) can reduce psychic tension and thereby help the patient to accept necessary restrictions more calmly, and to adjust to his illness more realistically.

Getting back to work presents additional stresses for the cardiac patient. There are often anxiety-producing features in the job which can be more significant than the physical or intellectual demands of the work. Valium (diazepam), 2 mg or 5 mg t.i.d., may be a useful adjunct to reduce overreaction to these stresses and thus help the patient to face job situations more calmly and rationally.

back at work...
(2 mg or 5 mg t.i.d.)



Valium® (diazepam)

to help relieve psychic tension

and for the patient with tension-induced sleeplessness, remember the value of an extra tablet at bedtime

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, moderate to severe psychoneurotic states with anxiety, apprehension or agitation alone or with depressive symptoms; somatic complaints which are concomitants of emotional factors; acute agitation due to alcohol withdrawal; muscle spasm associated with cerebral palsy and athetosis.

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d.

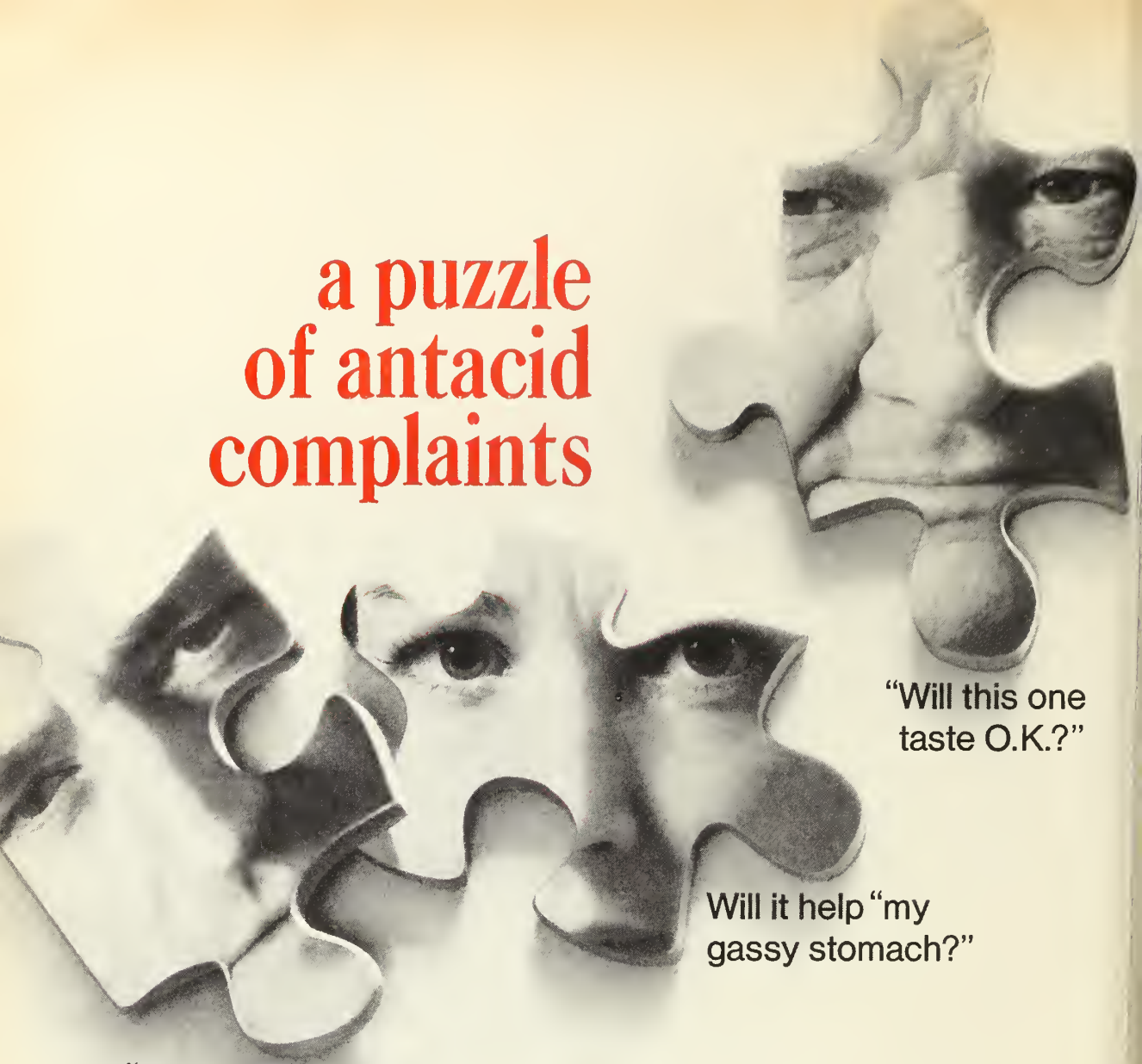
Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

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Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

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Practice of Podiatry Redefined...

Amended House Bill No. 662 Enacted by the Ohio General Assembly Clarifies Aspects of the Law Regarding This Field of Practice

BEFORE ITS RECESS on September 8, 1967, the 107th Ohio General Assembly passed a number of outstanding legislative measures pertaining to the medical and health field (November issue of *The Journal*), among them a statute which redefines the practice of podiatry. In order to properly evaluate this new legislation, *The Journal* requested the help of W. Thomas Washam, M. D., LL. B., Executive Secretary of the State Medical Board of Ohio, who presented the following interpretation.

Amended House Bill No. 662 enacted by the 107th General Assembly of the State of Ohio, redefines the practice of podiatry as follows:

> Section 4731.51. The practice of podiatry consists of the medical, mechanical, and surgical treatment of ailments of the foot; and superficial lesions of the hand other than those associated with trauma. Podiatrists are permitted the use of such preparations, medicines, and drugs as may be necessary for the treatment of such ailments. The podiatrist may treat the local manifestations of systemic diseases as they appear in the hand and foot, but the patient shall be concurrently referred to a doctor of medicine or a doctor of osteopathic medicine and surgery for the treatment of the systemic disease itself. General anesthetics may be used under this section only in colleges of podiatry approved by the Medical Board pursuant to Section 4731.53 of the Revised Code and in hospitals approved by the Joint Commission on the Accreditation of Hospitals, or the American Osteopathic Association. The use of x-ray or radium for therapeutic purposes is not permitted.

The previous statute which defined the practice of chiropody (podiatry) restricted the legally permissible scope of practice on the basis of the therapeutic use of the medication prescribed. This statute stated, "In practice, chiropodists are permitted the use of local antiseptic preparations and local anesthetics, analgesics, and antibiotics." This was difficult to fairly interpret and enforce due to the multiple effect of some medications.

The new statute sets forth scope-of-practice limitations on an anatomical and pathological basis and further provides that while local manifestations of systemic disease in the hand or foot may be treated by the podiatrist, the patient shall be concurrently referred to a physician for the treatment of the systemic disease.

This provision was discussed by members of the professions and in legislative committees. It was considered desirable in that it benefits primarily the patient by requiring that broad scope of professional care be made available in those conditions requiring it.

We are hopeful that as a result of this provision there will be more frequent communications between the professions with resultant better mutual understanding and teamwork.

The prior statute defining the practice of chiropody (podiatry) prohibited operative procedures requiring the use of a general anesthetic.

The new statute provides that general anesthetics may be used in accredited hospitals or in colleges of podiatry approved by the medical board. It was felt that the previous restriction to local anesthetics only did not restrict the scope of practice of poditary, but denied the patient the benefit of general anesthesia in circumstances and facilities where it was desirable.

It would be too optimistic to presume that the medically related legislation recently enacted solves all of the problems which have accumulated over the past years. However, the recent broad revision of the Medical Practice Act must be considered a great step forward in Ohio. The broad support of this legislation indicates there is widespread interest in good government and proper health regulation in our state.

There should be increasing awareness of the necessity for continuing revision and updating of medically related legislation.

The health professions should accept this necessity as both a challenge and an obligation.



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In addition the AMA TV network will present more than 40 hours of convention news.

Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, June 19, 1968. Since space is limited, we suggest you make your reservations before June 3, 1968. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 6, 1968.

SAN FRANCISCO, CALIFORNIA · JUNE 16-20, 1968

AMERICAN MEDICAL ASSOCIATION'S 117th ANNUAL CONVENTION · BROOKS HALL

Physician-Republican to Run for Congress in 18th District

Dr. James F. Sutherland, practicing physician of Martins Ferry, and a lifetime resident of that Ohio Valley area, has announced that he will be a Republican candidate for Congress from the 18th Congressional District. The Republican candidate named in the May Primaries will run against incumbent Democratic Congressman Wayne L. Hays.



Dr. Sutherland

Dr. Sutherland, a general practitioner, received his education in the Martins Ferry school system, Linsly Military Academy, and his undergraduate degree from Washington and Jefferson College. He received his M. D. degree from the University of Pennsylvania School of Medicine.

During World War II he served with the U. S. Navy, and for an additional military tour, he served from 1955 to 1957 as a lieutenant commander in the Naval Medical Corps.

Affiliations include membership in several professional and honorary societies, as well as the American Legion. He is also a member of the Advisory Council of the Ohio Bureau of Vocational Rehabilitation and is chairman of a subcommittee of the Federal Poverty Health Programs. He is president of the Ohio Chapter of General Practice and president-elect of the Medical Staff at Martins Ferry Hospital. He and his wife, the former Diana Westlake, of Colerain, have three daughters. His campaign manager is Karl W. Sommer, Jr., Martins Ferry attorney.

Provisions in the OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cincinnati, May 13-17.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 18.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 1 (a), entitled "Nomination of President-Elect."

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Carroll County Society Announces Topics for April 3 Seminar

The Carroll County Medical Society's Fourth Annual Postgraduate Seminar will include four outstanding speakers and topics of interest to physicians in their daily contacts with patients. The seminar will be held on Wednesday, April 3, at the Atwood Yacht Club, Atwood Lake, Route 1, Dellroy. Registration begins at 8:00 A. M., and the program at 9:00 A. M. The speakers and their topics are as follows:

Dr. Raymond Jordan, University of Pittsburgh School of Medicine, "The Dizzy Patient."

Dr. Richard L. Witt, University of Cincinnati College of Medicine, "Pneumonias."

Dr. Herbert C. Flessa, University of Cincinnati College of Medicine, "Anemias."

Dr. William B. Ford, University of Pittsburgh School of Medicine, "Operation for You, Doctor" (Heart).

Dr. Thomas J. Atchison, secretary of the Society, announced that American Academy of General Practice continuation study credit was authorized for the course. An all-day program for the ladies also will be provided.

Training Tips for Public Speakers Available Through AMA Kit

When it's time to deliver a speech, are you at a loss for words? Is your approach ineffective? Are you confronted with "delivery dilemma?" A possible solution to these typical problems is now provided by the Officers Services Department of the American Medical Association.

An invaluable kit, "An Aid to Speakers," may be the key to individual success and/or the success of a program. It contains source materials, ranging from generalized speeches aimed at lay audiences to numerous up-to-date training tips. Physicians may obtain single copies free of charge by directing their requests to the Officers Services Department. Quantities of up to 50 are made available to state and county medical societies sponsoring formal speakers programs.

What Goes On — K. I. O.

The Medical Foundation of Cincinnati, an affiliate of the Academy of Medicine of Cincinnati, is publishing "What Goes On — K. I. O." for distribution to physicians and medical students in the tri-state area. "What Goes On" is a physician's guide to continuing educational opportunities in Kentucky, Indiana, and Ohio. It will be published nine times a year (the first issue was distributed in January), and will present detailed chronological accounts of current and future postgraduate medical courses, meetings, and continuing educational opportunities.

The publication is made possible through the courtesy of Lederle Laboratories, a Division of American Cyanamid Co. Physicians, and executive staffs are invited to send information on future meetings to G. S. Accetta, M. D., 320 Broadway, Cincinnati, Ohio 45202 (Phone: 513-721-2345). Information for the brochure should be sent in six weeks before publication date. Inquiries in regard to distribution of "What Goes On" may also be directed to Dr. Accetta, at the foregoing address which is also the headquarters of the Academy of Medicine of Cincinnati.

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ACCREDITATION NOTES . . .



A Question-and-Answer Column Conducted in Collaboration with

The Joint Commission on Accreditation of Hospitals

John D. Porterfield III, M. D., Director

Q. What is the governing body of JCAH and what is its composition? How many, for instance, are physicians, and are these practicing physicians or full-time hospital physicians?

A. The corporation of JCAH has the American Medical Association, the American Hospital Association, the American College of Physicians, and the American College of Surgeons as Members. In addition, the American Association of Homes for the Aging and the American Nursing Home Association are nonmember supporting organizations. Each of these six associations appoints Commissioners to the Board of Commissioners which is the governing body of JCAH, setting standards, adopting policy, employing the Director, making accreditation decisions on the institutions surveyed.

There are 22 Commissioners, seven from AMA, seven from AHA, three from ACP, three from ACS, one from AAHA, one from ANHA. Of these 22 Commissioners (1967), 17 are physicians, three are professionally engaged in hospital organization and administration, two are professionally engaged in extended care facility administration. Of the 17 physicians, 13 are in the active practice of clinical medicine, two are in hospital administration, one is in government medical administration, and one is in full-time education in the health and hospital sciences. Of the 13 physicians in active medical practice, four are in suburban or rural practice, five are in urban practice, four practice in a medical education center setting. A Commissioner serves for three years, with the privilege of reappointment.

Q. Are there various grades or classes of accreditation, or is there simply one overall "accreditation" to cover any hospital, whether it be community type, teaching, in a large city, in a small city, etc?

A. There is only one accreditation for hospitals, whatever the size or setting. However, a hospital may be given full accreditation (calling for resurvey in about three years) or provisional accreditation (requiring resurvey in about one year), depending upon the relation of its operation to the accreditation standards. If a hospital does not meet standards, accreditation is not granted. There are no "classes" of accreditation, the JCAH believing that any hospital should provide the required services at a stated level of quality and, if it chooses to provide the optional services, that they be up to standard. This device of standards for required and for optional services allows them to be used to measure any type or size of hospital.

Q. What happens to a hospital if it does not pass the requirements and thus is not accredited by the JCAH? Can the status of a hospital be changed from "accredited" to "not accredited" and vice versa, and, if so, what would be some of the factors that might change this status of accreditation?

A. If a hospital is not accredited after survey, it may, if it believes the decision incorrect, appeal for a hearing before a committee of the Board. If it accepts the decision or the appeal is denied, it may apply for a new survey six months after the previous one. All hospitals after accreditation decision is made, yes or no, receive a "consultation critique" which lists the deficiencies the JCAH believes are present. This gives the hospital a document to guide the consideration of changes or improvements it may decide to initiate.

An accredited hospital, on resurvey in one or three years, may be found now not to be in sufficient conformance with accreditation standards. It will then become nonaccredited. A hospital which had not been given accreditation may on a later survey be found in conformance to the standards and will then be accredited.

Frequent causes of nonaccreditation decision are inadequate or obsolete organization of the governing body or medical staff, failure to demonstrate adequate performance of the functions of a medical staff listed in the standards (see JCAH Bulletin 40, January, 1966), incomplete and dangerously inadequate clinical charts, insufficient registered nurse personnel, dangerous fire hazards in the physical plant, illegal use of unlicensed personnel for patient care and medical practice.

Ad Astra

John Adams Baird, M. D., Yankeetown, Fla.; Western Reserve University School of Medicine, 1924; aged 72; died September 14; former member of the Ohio State Medical Association. A former practitioner in Ohio, Dr. Baird was at New Reigel during early years and later associated with the Veterans Administration and the National Military Home in Montgomery County before 1940. He was a veteran of World War II and after the war was associated with the Veterans Administration.

Arthur G. Beyer, M. D., Cincinnati; Rush Medical College, 1914; aged 80; died January 23; former member of the Ohio State Medical Association and the American Medical Association; member of the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Otolaryngology. A practitioner over a period of more than 50 years, Dr. Beyer moved to Cincinnati in 1924 and specialized in the ENT field. In addition to his professional affiliations, he was a member of the Presbyterian Church and the Literary Club. His widow survives.

William Eustis Brown, M. D., South Burlington, Vt.; Harvard Medical School, 1920; aged 80; died January 4; former member of the Ohio State Medical Association. A former Cincinnati physician, Dr. Brown was associate professor on the faculty of the University of Cincinnati from 1924 to 1944. He went to Vermont in 1945 as dean and professor of preventive medicine. His widow and a son survive.

Lawrence Ogle Carpenter, M. D., Santa Rosa, Calif.; Western Reserve University School of Medicine, 1949; aged 44; died July 26; former member of the Ohio State Medical Association. A former practitioner in the Coshocton area, Dr. Carpenter left Ohio about 1954.

Leroy Edgar Chapman, M. D., Warren, Pa.; Starling Medical College, Columbus, 1906; aged 86; died July 16. Available records show Dr. Chapman as a resident of Warren, Pa., from early in his career.

Earl Keyser Conrad, M. D., Johnstown, Pa.; Eclectic Medical College, Cincinnati, 1906; aged 85; died May 9. Dr. Conrad was a resident of Johnstown, Pa., for many years, according to available records.

Frank P. Corrigan, M. D., Old Greenwich, Conn. (formerly of Cleveland); Western Reserve University School of Medicine, 1906; aged 86; died January 21; member of the Ohio State Medical Association. A former surgeon and U. S. diplomat, Dr. Corrigan maintained his residence in the Cleveland area until recently. His interest in diplomatic affairs originated out of experiences as chief surgeon for the Chile Exploration Hospital during World War I. In the 1920's he began organizational work in South America for the American College of Surgeons, and later served as its international representative; also as its representative to the U. N. His career included a number of diplomative missions. A daughter, three sons, and a brother are among survivors.

Wallace N. Davidson, Sr., M. D., Cushing, Okla.; University of Oklahoma School of Medicine, 1919; aged 75; died January 12. A practitioner of long standing in Oklahoma, Dr. Davidson was a veteran of both World Wars and a retired Colonel in the Medical Corps. Dr. Wallace N. Davidson, Jr., of Dayton, is his son.



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Melvin Edgerton Deuel, M. D., Geneva, N. Y.; Ohio State University College of Medicine, 1925; aged 69; died August 20. Dr. Deuel served most of his professional career in the Geneva, N. Y., area.

David Wuest Exley, M. D., Miami, Florida; University of Cincinnati College of Medicine, 1935; aged 56; died September 4. Dr. Exley served virtually all of his professional career in the Miami area.

William Russel Gibson, M. D., Fairborn; Ohio State University College of Medicine, 1932; aged 62; died January 11; former member of the Ohio State Medical Association. Dr. Gibson was a practitioner at Oak Harbor for many years and medical officer for the Erie Army Depot in northern Ohio. Recently he was medical officer at Wright Patterson Air Force Base. Among survivors are his widow, two daughters, and a brother.

Wade Schoonover Helwig, M. D., Cleveland; Ohio State University College of Medicine, 1956; aged 39; died January 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Helwig entered general practice in the Euclid area after completing his internship and residency training in Cleveland. He is survived by his widow, a son, two daughters, and his mother.

Yu-Ying Tsing Huang, M. D., Canton; Tung Teh Medical College, Shanghai, 1947; aged 47; died November 17; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A native of China, Dr. Huang took her internship training at Nanking Central Hospital and St. Joseph's Hospital in Elmira, N. Y. She had three years of residency training at Deaconess Hospital, Spokane, Wash., and Highland Hospital, Rochester, N. Y.; also postgraduate work in public health and bacteriology at Washington State College. In Canton she did general practice and obstetrics. She was a member of the Baptist Church and the International Club. Survivors are her husband, Dr. Teh-Chang Huang, research director at Timken Mercy Hospital, and two daughters; also a sister and three brothers in China.

William B. Landesman, M. D., Cleveland; medical degree from Franz Joseph University, Szeged, Hungary, 1917; aged 72; died on January 5 while on vacation in Florida; member of the Ohio State Medical Association. A native of Hungary, Dr. Landesman came to this country in 1919, and moved to Cleveland in 1921. He practiced for many years in the Euclid area and later in Cleveland Heights. He was a member of the Temple and of the Masonic Lodge. Survivors include his widow, a daughter, and a son, a sister, and a brother.

John W. Leichliter, M. D., Cincinnati; University of Cincinnati College of Medicine, 1928; aged 67;

(Continued on Next Page)

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died August 3; member of the Ohio State Medical Association, the American Medical Association, the American Society of Clinical Pathologists, and the Association of Military Surgeons. A practicing pathologist for many years in Cincinnati, Dr. Leichliter extended his field to Wilmington and Georgetown hospitals. During World War II he served with the armed forces including assignments in the Southwest Pacific areas. A son survives.

Cornelius G. Lynch, M. D., Richmond, Va.; University of Michigan Medical School, 1930; aged 64; died January 18; former member of the Ohio State Medical Association. A native of Toledo, Dr. Lynch practiced there between 1931 and 1941, going into military service during World War II. He was chief anesthesiologist at McGuire Veterans Hospital in Richmond. His widow survives.

Miriam Ruth Marting, M. D., Ironton; University of Cincinnati College of Medicine, 1931; aged 62; died January 3. Member of a prominent physician family, Dr. Marting practiced at one time in Ironton in association with her father, the late Dr. W. F. Marting, specializing in the EENT field. She later left the state for health reasons and practiced for a while in Knoxville, Tenn., before returning to Ironton. Among affiliations, she was a member of the Methodist Church. Two sisters who also are physicians, survive, Dr. Esther C. Marting Fabing, of Cincinnati, and Dr. Anne Marting Alstott, of Ironton.

Edward Wolcot Parsons, M. D., Cleveland; Western Reserve University School of Medicine, 1926; aged 67; died January 13; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Internal Medicine. A practitioner of long standing in the Cleveland area, Dr. Parsons specialized in internal medicine. For several years he had been examiner for the Ohio Industrial Commission. A member of the Baptist Church, he is survived by his widow, two sons, and two sisters.

Wess E. Sroub, M. D., Cleveland; Western Reserve University School of Medicine, 1924; aged 72; died January 7; member of the Ohio State Medical Association. A physician and surgeon in Cleveland for some 43 years, Dr. Sroub also was physician for the Cleveland school system. Among affiliations he was a member of the Catholic Church and the Third Order of St. Francis. Survivors include two sons, two brothers, and two sisters.

Harry Rupert Werner, M. D., Akron; Eclectic Medical College, Cincinnati, 1906; aged 86; died January 3; member of the Ohio State Medical Association. A native of West Virginia, Dr. Werner practiced there before moving to Akron in 1920. He retired in 1946 and maintained homes in Cedarville, Mich., as well as in Akron. Affiliations included memberships in the Knights of Pythias, Moose and Elks Lodges. Surviving are his widow, and two sons, one of whom is Dr. Marshall R. Werner, also of Akron.

William Winslow Wiedemann, M. D., Toledo; St. Louis University School of Medicine, 1927; aged 64; died January 13; member of the Ohio State Medical Association. Dr. Wiedemann devoted all of his professional career to practice of medicine and surgery in Toledo. He was a member of the Catholic Church, the Holy Name Society, and the Knights of Columbus. Among survivors are his widow, three sons, two daughters, and a sister.

Robert T. Wise, M. D., Cleveland; Meharry Medical College, 1918; aged 76; died January 21. A general practitioner, Dr. Wise devoted nearly a half century to practice in the Cleveland area. A member of the Prince Hall Affiliation of Masons, he is survived by his widow and a brother.

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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Activities of County Societies . . .

FRANKLIN

Physicians honored for outstanding service as members of the profession over a period of 50 years at a recent meeting of the Academy of Medicine of Columbus and Franklin County are Dr. Forest C. Haney, Dr. Fred E. Hall, and Dr. Edgar B. Junkermann. Presentations were made at the meeting by Dr. Richard L. Fulton, Councilor of the Tenth District, in behalf of the Ohio State Medical Association. Presentations were made later also to Dr. George O. Haskins and Dr. Anton W. Oelgaetz, who were not able to be present.

Governor James A. Rhodes was honored guest and speaker for the January 16 meeting of the Academy at the Imperial House North, in Columbus. The Governor discussed the Ohio program for betterment of the State as it relates to professional and other groups.

LORAIN

The regular meeting of Lorain County Medical Society featured as speaker of the evening Glidden L. Brooks, M. D., President of the Medical College of Ohio at Toledo. With a background of impressive accomplishments in the field of pediatrics and medical education, Dr. Brooks was appointed to his present position at Toledo in 1966. "Current Trends in Medical Education" was the theme of his presentation . . . in which he outlined the changes, new problems, and possible new diseases, that must be anticipated in the future, and he explained how Medical Education Facilities are rapidly adjusting to meet this challenge.

William R. Schultz, M. D., Councilor of the Eleventh District, was among the guests present.

During a brief business session prior to the evening's program, Certificates of Active Membership in the Society were awarded to Rupert O. Clark, M. D., of Oberlin, and Charles N. Horvath, M. D., of Lorain, who were elected to "Active" status on December 12, 1967, and to Sami A. Sfeir, M. D., of Lorain, elected on February 13, 1968.

MAHONING

The annual meeting of the Mahoning County Medical Society was held on December 19 in the Mural Room, Youngstown. A social hour was followed by a buffet dinner and a meeting at which officers for 1968 were elected.

Dr. Robert R. Fisher is the incoming president, succeeding Dr. H. J. Reese. Dr. J. W. Tandatnick was named president-elect; Dr. Henry Holden, secretary; and Dr. M. C. Raupple continues as president.

Installation of officers was announced for the January 16 meeting.

MONTGOMERY

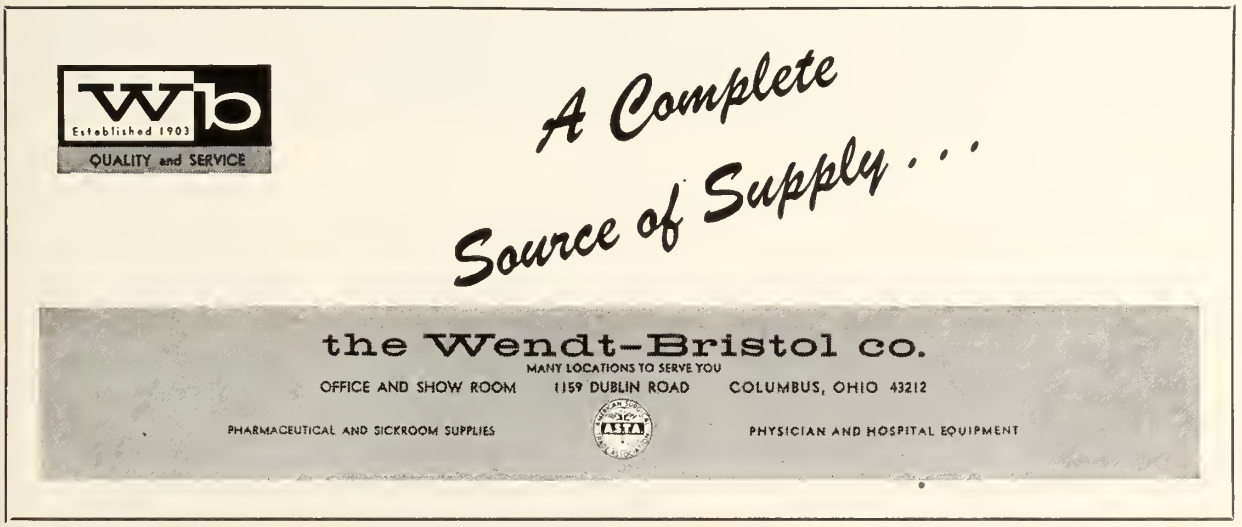
The 119th Annual Presidential Inaugural meeting of the Montgomery County Medical Society was held at the Sheraton-Dayton Hotel, preceded by a reception and dinner.

Dr. Peter A. Granson, 1968 president, gave the President's Address, as part of the inaugural ceremonies. He was installed with Dr. James G. Tye, president-elect; Dr. Junius E. Cromartie, vice-president; Dr. Joseph M. Albrecht, secretary; and Dr. R. Alan Fanning, treasurer.

Entertainment for the occasion was furnished by members of the Society including the Montgomery County Medical Society Glee Club.

It was announced that Earl E. Shelton had been named executive secretary. He has been acting in that office since the death of Robert F. Freeman last October.

Mr. Shelton has been with the Society since 1961 as comptroller and assistant executive secretary. He also assumes the positions of executive director of the Medical Society Telephone Service and the Bureau of Medical Economics.





Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hype thyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine an other related adrenergic neuron-blocking agents.
The drug is not recommended at th present time in patients under 12 yrs of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, turbances of accommodation, swe ing, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with suc symptoms as hallucinations and di orientation), activation of psychos n schizophrenics and agitation (incl

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hypomanic and manic episodes) ch may require dosage reduction / or addition of a tranquilizer or porary discontinuation of the drug, eptiform seizures, orthostatic otension and substantial blood ssure fall in hypertensive patients, ura, transient jaundice, bone mar- depression including agranulocy- s, sensitization and skin rash uding photosensitization, eosino- ia, and mild withdrawal symptoms udden discontinuation after pro- ed treatment with high doses. asional hormonal effects (im- nce, decreased libido, and estro- c effects) may be observed. pine-like effects may be more ounced (e.g. paralytic ileus) in eptible patients and in those g anticholinergic agents (includ- ntiparkinsonism drugs).

atient Adult Dosage: Initially, g. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.

A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.

Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

SEE IT — peeking over the horizon? Feel it in the air? Hear the echo of terrific activity from Cincinnati? Note the vibrations of expectancy all over the state? Sure 'nuff! It is getting closer and closer — and what else could I be meaning but CONVENTION TIME! Yup — it won't be too long now — that 28th annual convention of the Woman's Auxiliary to the Ohio State Medical Association.

Scheduled for the merrie month of May (and as I write this in the freezing, snowy depths of February, it looks like a little bit of Heaven!) the 1968 annual meeting will be neatly fitted into two days — Wednesday, May 15, and Thursday, May 16. For Board members, it will mean three days of participation, with the Board Luncheon set for noon on Tuesday, May 14, to be followed by the preconvention Board meeting. Headquarters for the Auxiliary will be the Queen City's Terrace-Hilton Hotel, a unique, ultra-modern hostelry of no small interest (the lobby isn't where you'd expect a lobby to be!)

It always takes two women in particular to bring a convention to life — and of course who else but the ingenious cochairmen this year, Mrs. Harry Fry and Mrs. Carl Schilling! And under their inspired leadership is the core of convention — the dedicated, indefatigable committees full of enthusiasm, ideas, originality and purpose. We salute you all!

There is a new "first" this year — another privilege accorded the Auxiliary by its parent organization. We shall have our own displays at the Cincinnati Exposition Center — a wonderful opportunity to present the Auxiliary picture to the doctors themselves. Imagine having a booth of our own among the scientific exhibits that draw such crowds . . . Consider the value of featuring Auxiliary projects on the national, state, and county level . . . And again this year, the OSMA has invited us to join the doctors at their 1:30 P. M. General Sessions. This is a privilege that we cherish, an honor that we acknowledge with great pride, a recognition that we find deeply rewarding.

There will also be a "repeat performance" of last year's outstandingly successful Crafts and Hobby Exhibit. I don't mean that the same things will be shown but only that once again the ingenuity, talent, and artistry of our doctors' wives all over the state will be on display. Do you have handiwork to show (your own, of course)? Ceramics? Paintings? Knitted "goodies"? Dressmaker creations? Needlepoint? Jewelry? Wood carving? Crewel embroidery? Anything and everything that your nimble fingers and talented hands have produced? Don't be unduly modest about your own handiwork, please! Let's see it, and enjoy it! Get in touch with chairman Mrs. Arden Steele, P. O. Box 67, Loveland, Ohio. And do it NOW . . .

Wednesday Luncheon

There will be two VIPs as honored guests at the "Americana" luncheon — Mrs. Karl Ritter, Ohio's own National Auxiliary President, and Dr. Edward R. Annis, Past President of the AMA and a nationally prominent and dynamic speaker. Because both of these wonderful people have a strong sense of dedication and a fervent love of country, the convention cochairmen decided to feature a patriotic theme for this Wednesday luncheon to point up the conviction that the medical profession believes in America, stands up for America and can be positive about America!

Originally it was intended to use the patriotic theme only for the luncheon but then the idea took

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THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President: Mrs. Paul Sauvageot
2443 Ridgewood Rd., Akron 44313

President-Elect: Mrs. Malachi W. Sloan, II
415 Towerview Rd., Dayton 45429

First Vice-President: Mrs. Edward L. Doerman
3605 Laskey Rd., Toledo 43623

Recording Secretary: Mrs. James W. Loney
15450 Hemlock Point Rd., Chagrin Falls

Second Vice-President: Mrs. Carl F. Goll
1001 Granard Pkwy., Steubenville 43952

Corresponding Secretary: Mrs. Duane E. Banks
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Third Vice-President: Mrs. Harry L. Fry
1071 Celestial St., Apt. 1804,
Cincinnati 45202

Past President and Nominating Chairman:
Mrs. James N. Wychgel
3320 Dorchester Rd., Cleveland 44120

Treasurer: Mrs. Russell L. Wiessinger
2280 West Wayne St., Lima 45805

even greater hold and finally became the theme of the entire convention. I am advised that the luncheon decorations will feature big flags and little flags, a big golden eagle on the speakers' table, and centerpieces of red, white, and blue drums topped with Ohio's red carnation. These drums will be 7½ inches tall, royal blue with red stripes around top and bottom, white cord trim and crossed drumsticks on top. It sounds spectacular! This noon festivity will be held in the Pavillon Caprice of the Netherland Hilton Hotel.

Wednesday afternoon from 3 to 5 P. M. will highlight (back at the Terrace) "Scenes and Schemes of the County Auxiliaries" as well as AMPAC-OMPAC. Some county presidents will be showing colored slides of outstanding projects; others will tell about outstanding activities. Either way, it will be informative and stimulating. Also that same afternoon, voting on the '68-'69 slate is scheduled between the hours of 2:30 and 5:30 P. M. in Parlor A at the Terrace Hilton. The morning's important business session will be from 9 to 11:30 A. M. and conducted by Mrs. Paul Sauvageot, state president.

And at 7:00 P. M. that night, OSMA's fun-spirited Gaslight Party is on the agenda! (If you attended the one last year, you won't have to be coaxed to come to this one . . . Wotta night that was — wotta party!) There will be entertainment direct from Chicago's Gaslight Club, Al "Mr. Banjo" Meyers and his band of entertainers, the "Back Room Boys," dancing, contests, prizes, snacks, beer . . . All this for only $8 per person.

Chef Gregory

Cincinnati's most famous French chef and cooking school instructor will be the star attraction at the Thursday morning breakfast in the ballroom of the Terrace Hilton. It will be a "French Country Breakfast" (how could it be anything else with such a distinctive name as our President's — Sauvageot???). Ludel points out that we're going in for French cooking at home this year rather than traveling abroad to taste it!

The ballroom will be resplendent as a flower market and again the colors will emphasize red, white, and blue. There will be gourmet "touches" at the breakfast which I'm not allowed to reveal (the committee wants to surprise you) and Chef Gregory will demonstrate the preparation of two special, mouth-watering French dishes. Said breakfast is scheduled at 7:30 A. M. Sounds awfully early, I know but it will be well worth the effort! This early morning festivity is in honor of the county presidents, past state presidents and National guests. Whatever else you may forget, don't forget your alarm clock . . .

The second business session will start promptly at 9:00 A. M. (also in the ballroom). And at 11:30 A. M., there will be a reception honoring the newly elected Board (in the Ohio Valley Room). Mont-



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gomery County — "home" of President-Elect Mrs. Malachi W. Sloan, II — will hostess the reception (sherry 'n all) for its own Jane, of whom the group is exceedingly and understandingly very proud . . .

Guess I'd better not forget mention of the boat ride and dinner on the S. S. Jubilee Tuesday night at 7:00 P. M. Fran Krone, Cincinnati's versatile publicity chairman, writes me "it will be an evening on the Beautiful Ohio with a bit of nostalgia for the old days . . . a calliope that will play as we pull away from the dock . . . honest-to-goodness Southern cooking . . . Dixieland tunes . . . Cincinnati's "Medi-Chords" (a group of six physicians who really have the beat) . . . in short, an intriguing 'steamboat round the bend' experience . . ."

OMPAC Luncheon

At noon on Thursday, the annual OMPAC luncheon will be held in Room 210 at the Cincinnati Exposition Center, with the Honorable Robert Taft, Jr., as guest speaker. Tickets are $5.00 per person and all Auxiliary members are not only invited but are urged to attend. To say that this year of 1968 is a vitally important and crucial election year is the understatement of the year! There's a mighty big job ahead for each and every one of us (as if you didn't already know that!).

Here's an item that the men may be particularly interested in noting — there will be 30 young, attractive doctors' wives who will serve as information gals in three spots throughout convention (not the 30 in any one spot, of course!!) — at convention hall itself and at headquarters in both hotels (the doctors' headquarters is the Netherland Hilton). The girls will be easily recognized because they will be in costume — and can you guess the color of those costumes? What else but red, white, and blue . . .

It strikes me as a good idea, at this point, to put the spotlight on our State President, Mrs. Paul Sauvageot, whose convention this is. She will, of course, "reign" over it. Nor should the important part she has played in helping to plan her convention be overlooked. I know that Frankie Fry and Marge Schilling would want that noted — and I know too they'd appreciate the mention of their own committee chairmen. So here goes:

Adviser, Mrs. Calvin Warner; Finance, Mrs. Maurice Marsh, Mrs. Ralph Grace; Liaison, Mrs. Robert Heidt, Mrs. Edward Hartenian; Registration, Mrs. James Wiseman, Mrs. Robert Johnstone; Roll Call, Mrs. Emil Barrows, Mrs. Elliott Hilsinger; Tickets, Mrs. Kent Martin, Mrs. William Ahlering; Printing, Mrs. John Toepfer, Mrs. George Haydon; Publicity, Mrs. Robert Krone, Mrs. Haydon; County Displays, Mrs. William Jennings, Mrs. Hudson Baumes; Guests, Mrs. Herman Nimitz, Mrs. James Mills; Graft Show, Mrs. Arden Steele, Mrs. Charles Simmons; Pages, Mrs. Herbert Brinker, Mrs. Don Berning; Hospitality, Mrs. Makoto Yamaguchi, Mrs. Charles Blase; Meeting Rooms and Signs, Mrs. Ben Friedman, Mrs. Ben Yamaguchi, Jr.; Sponsors, Mrs. John Harding, Mrs. Edmund Schweitzer; Typing, Mrs. Albert DeGarme; Tuesday Night Party, Mrs. Earl Van Hern, Mrs. Curwood Hunter; Wednesday Luncheon, Mrs. Lloyd Larrick, Mrs. Roy Kile; Thursday Breakfast, Mrs. Warren Marvin, Mrs. Max Labermeier, Jr.

Registration and all Auxiliary meetings will be held at the Terrace Hilton. The Hospitality Room will be in the Ohio Valley Room (the Crafts Exhibit will be housed there too). And a word to the wise: get your hotel reservations in. The downtown hotels include the Terrace Hilton (15 West 6th Street), the Netherland Hilton (5th and Race Streets), the Sheraton-Gibson (421 Walnut Street) and Holiday Inn (8th and Linn Streets).

County Auxiliaries!

My apologies for omitting, in this issue, the items you were good enough to send me. The column this month had to be devoted to convention information. I'll make up for it next month — honor bright!



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Seminar on Diabetes Scheduled in Akron, Wednesday, March 27

The first annual post-graduate seminar on Diabetes Mellitus will be presented by the Summit County Diabetes Association on March 27. This is one of a number of scientific programs to be presented by the local Diabetes Association which recently became an affiliate of the American Diabetes Association.

The program will devote an entire day to various aspects of diabetes, with emphasis on the current work that is being done at some of the finest centers in this country. Moderator for the entire seminar will be Dr. Harvey C. Knowles, Jr., professor of medicine at the University of Cincinnati College of Medicine, and president-elect of the American Diabetic Association. The speakers and their subjects include the following:

1. Reubin Andres, M. D., Assistant Chief, Gerontology Research Center, NIH, Baltimore, Maryland, will talk on "The Significance of the Glucose Tolerance Test."

2. John C. Floyd, Jr., M. D., Associate Professor, Department of Internal Medicine, University of Michigan Medical Center, Ann Arbor, Michigan, will speak on "Hypoglycemia."

3. Dr. Knowles will lecture in the morning on "Pregnancy and Diabetes" and in the afternoon on "Management of Juvenile Diabetes."

4. Thaddeus Prout, M. D., Director of the Diabetes-Endocrine Clinic, Johns Hopkins Hospital, Baltimore, Maryland, will talk on "Insulin Resistance in Diabetes."

5. Robert F. Bradley, M. D., Joslin Clinic, Boston, Massachusetts, will lecture on Pituitary Ablation in the Treatment of Diabetic Retinopathy."

In addition there will be a panel discussion in the morning and one in the afternoon involving each of the participants in the seminar.

The program will be held in the auditorium of the new Holiday Inn at 200 East Exchange Street, Akron. The fee for the entire seminar will be $10.00, which will include the cost of the luncheon to be held on Wednesday, March 27. Fellows-in-training, residents and interns may attend the seminar and luncheon without charge; they should register by March 15. Registration also will be accepted at the meeting place on the day of the seminar from 8:00 - 9:00 A. M.

This program is acceptable for six hours continuation study credit by the American Academy of General Practice.

Any person desiring additional information on this program should contact I. R. Reisberg, M. D., chairman, Diabetes Seminar, 513 West Market Street, Akron, Ohio 44303.

Survival After Prolonged Coma

A committee of the Massachusetts General Hospital is studying the literature for an extensive report on extended periods of coma (over five weeks) followed by useful survival. The committee invites physicians to call attention to such documented cases which have not appeared in the literature, or which perhaps appeared in the literature under a title not indicative of survival after prolonged coma. Communications should be directed to William H. Sweet, M. D., Chairman, Committee on Management of the Unconscious Patient, Massachusetts General Hospital, Boston, Mass. 02114.

Dr. Norton J. Greenberger, Columbus, was guest speaker at the January 9 dinner meeting of the Fort Steuben Academy of Medicine, where he spoke on the subject, "Approach to the Jaundiced Patient." The meeting was held in the Fort Steuben Hotel, Steubenville.

Dr. F. David Fisher, Marion, recently left for a volunteer tour of service in Afghanistan with MEDICO, medical service sponsored by CARE.

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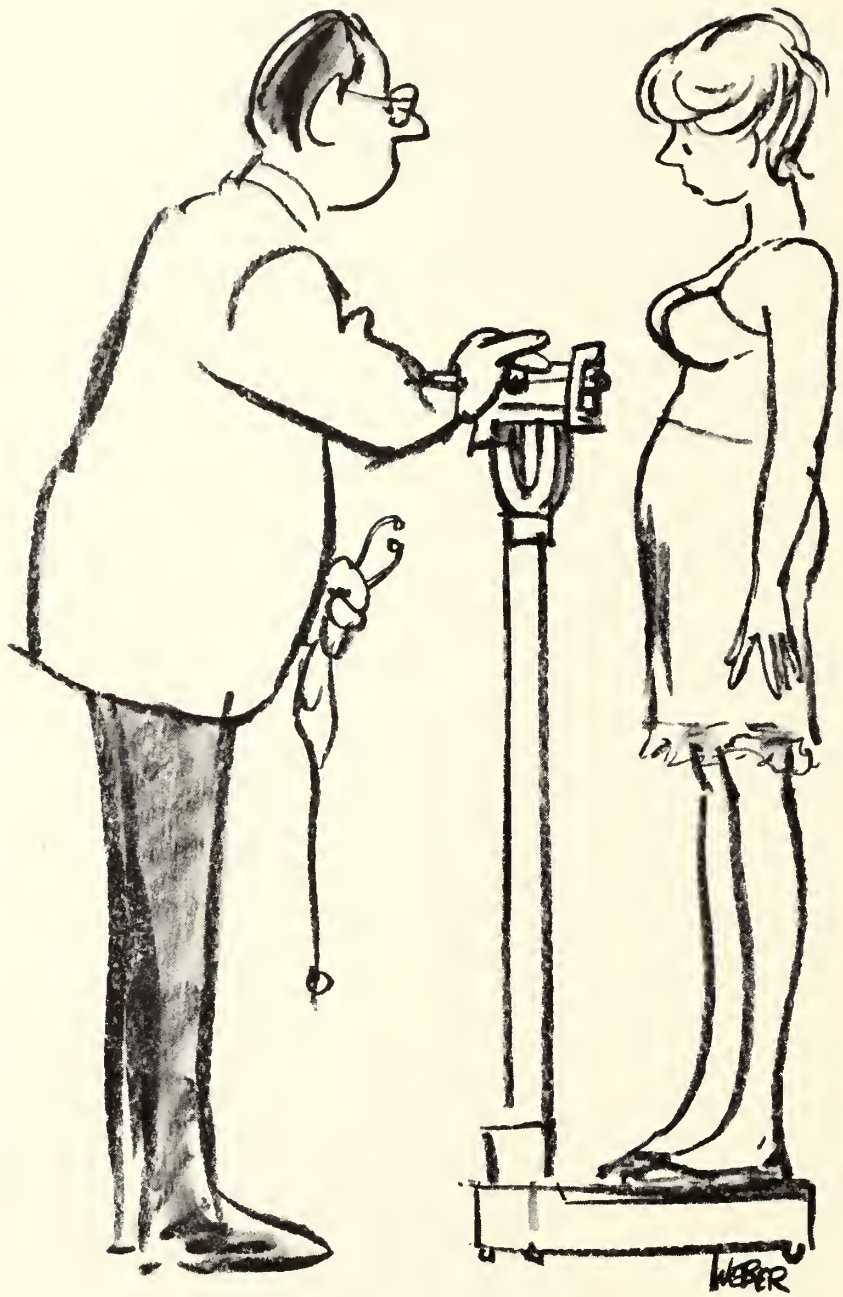


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Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association. 17 South High Street. Suite 500, Columbus. Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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WANTED: Orthopedic Surgeon for locum tenens for six months or any fraction thereof starting in January, 1968. Salary $2,500 per month. Permanent position possible. Reply Box 528, c/o Ohio State Medical Journal.

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MDs in the News

Dr. Joseph A. Freiberg, professor of surgery and director of the Division of Orthopedics, University of Cincinnati College of Medicine, has been elected an honorary fellow of the British Orthopaedic Association.

Officers of the Cleveland Society of Anesthesiologists are Dr. John P. Debly, president; Dr. Arnold S. Gale, vice-president; Dr. Gabriel P. Escobar, secretary; and Dr. John L. Hakes, treasurer.

Dr. Charles U. Hauser has returned to his practice of orthopedic surgery in Butler County after some 21 months of service as director of Medico, a service of the CARE program. Since 1959 he has served on several volunteer medical mission assignments overseas.

Dr. Adolfo D. Games, Warren, recently addressed the Ninth Argentina Congress of Gastroenterologists, where he presented a paper on the topic, "Endoscopic Diagnosis of Early Gastric Cancer."

Dr. Edward L. Miller, of Dennison, has announced his retirement from the practice of surgery in the Twin City (Dennison-Uhrichsville) area. Dr. and Mrs. Miller spent the winter in Florida.

Dr. Lucy Oxley, Cincinnati practitioner, was the subject of a feature article in the *Cincinnati Post & Times Star,* one of a series of articles running under the title "Careers in Health."

Dr. G. Douglas Talbott was honored by the Kettering Kiwanis Club and given the "Man of the Year" award of that organization.

Dr. Barnet R. Sakler, Cincinnati, was re-elected president of the American Association of Ophthalmology at the annual meeting of that organization in Chicago.

Dr. Louis J. Goorey was honored by the Worthington Junior Chamber of Commerce of which he is a member when he received the Jaycees Distinguished Service Award for the year.

Dr. Vermont D. Kearns was one of two Circleville residents presented the Outstanding Senior Citizens Award of the community.



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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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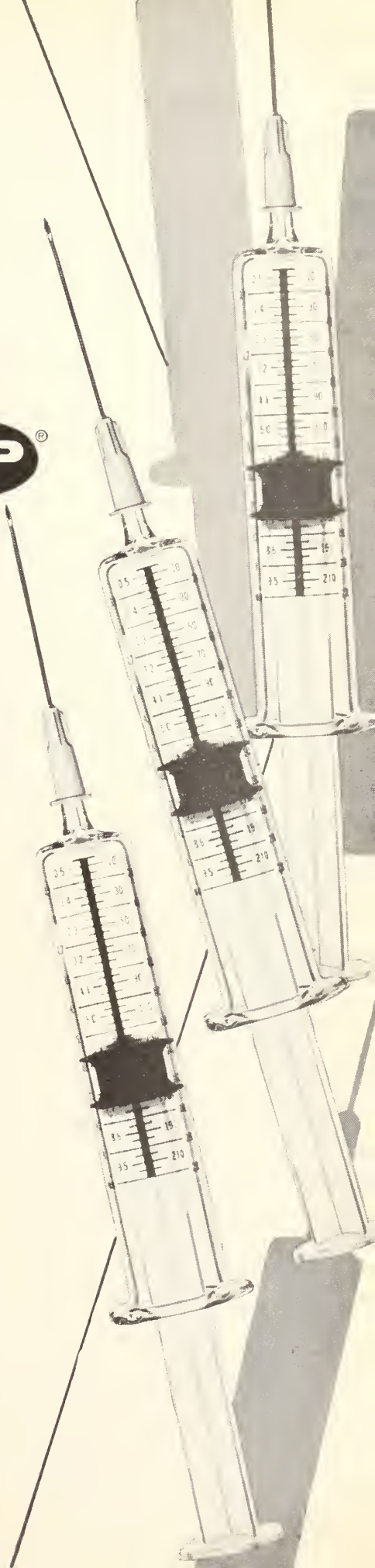
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STONEMAN PRESS, COLUMBUS, OHIO

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b.i.d.

The sensible schedule that covers the patient day and night

If your objective in the use of a broad-spectrum antibiotic is prolonged action, with high blood levels, then you know why b.i.d. DECLOMYCIN is considered to be a sensible dosage schedule.

The maintenance dosage of DECLOMYCIN can be kept at this convenient schedule because of its unusually high effective blood and tissue levels.

The b.i.d. dosage of DECLOMYCIN gives you the comfortable assurance that the patient is well-covered, *day and night.*

In clinical practice, blood levels produced by a therapeutic dose of DECLOMYCIN are high, prolonged, and effective; because of high serum binding and slow renal clearance. And if there's a broader susceptibility pattern of organisms, we've yet to see it.

There is no need to give higher daily dosage than 300 mg b.i.d., except in venereal diseases and Eaton Agent pneumonia.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

b.i.d. The sensible schedule that covers the patient day and night

DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosynerasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, N.Y.

Lederle

401-7—6046



Dietary Violations are Diminished Profoundly with...

†STEDYTABS Delfeta-sed ®

- **SEDAFAX** (brand of special micronized grade of AMOBARBITAL - Warning: may be habit forming).....**120 mg.**
- **DELFETAMINE** (brand of dl-N-METHYL-AMPHETAMINE HCl).....**30 mg.**

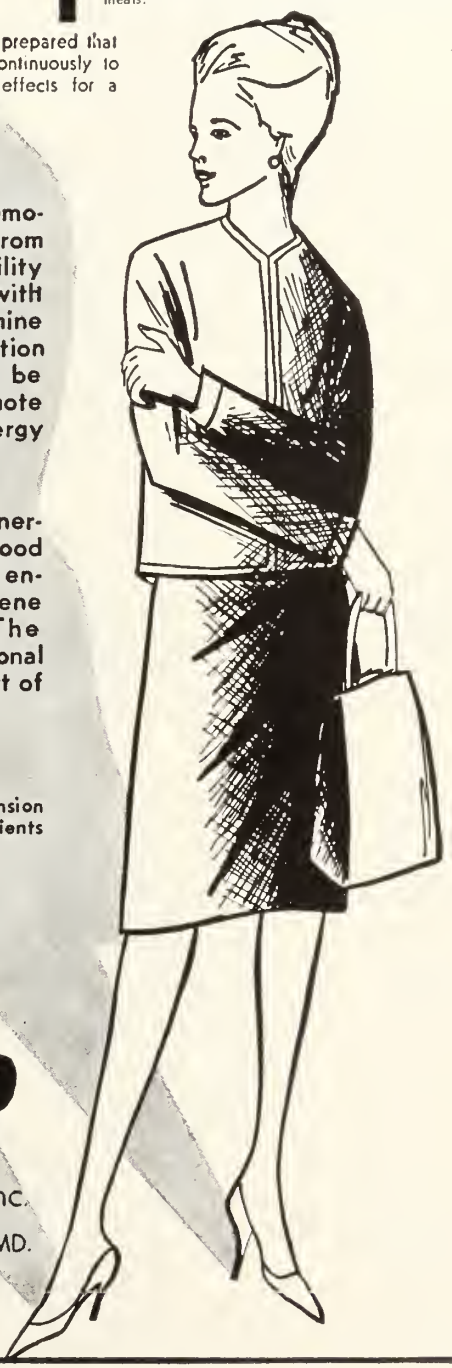
Usual Adult Dosage: **One tablet daily.* To be taken in the morning.**

Tablets Delfeta-sed* ®

- **SEDAFAX** (brand of special micronized grade of AMOBARBITAL - Warning: may be habit forming).....**40 mg.**
- **DELFETAMINE** (brand of dl-N-METHYL-AMPHETAMINE HCl.).....**10 mg.**

Usual Adult Dosage: In obesity, 1 tablet t. i. d. 30-60 minutes before meals. In all other conditions, take 1 tablet t. i. d. immediately after meals.

†STEDYTABS DELFETA-SED are so prepared that the active ingredients are released continuously to provide for prolonged therapeutic effects for a period of up to 8 to 10 hours.



The dieting obese sometime experience emotional problems as secondary symptoms resulting from restricted food intake: anxiety, depression, irritability and tension. Subjective relief is accomplished with Delfeta-sed (Delfetamine, dl-N-Methylamphetamine HCl) balanced with the mild euphoric sedative action of Sedafax, brand of Amobarbital-Warning: may be habit forming). The mood is altered to promote optimism and impart a cheerful sense of energy and well-being.

IN DEPRESSION: A completely logical synergistic combination of wide application as a mood normalizer for the common depressed states encountered in everyday practice. Induces a serene outlook without excessive tranquillity. The patient is alert but composed, free from emotional peaks and troughs. Relieves anxiety which is a part of every illness.

CAUTION:

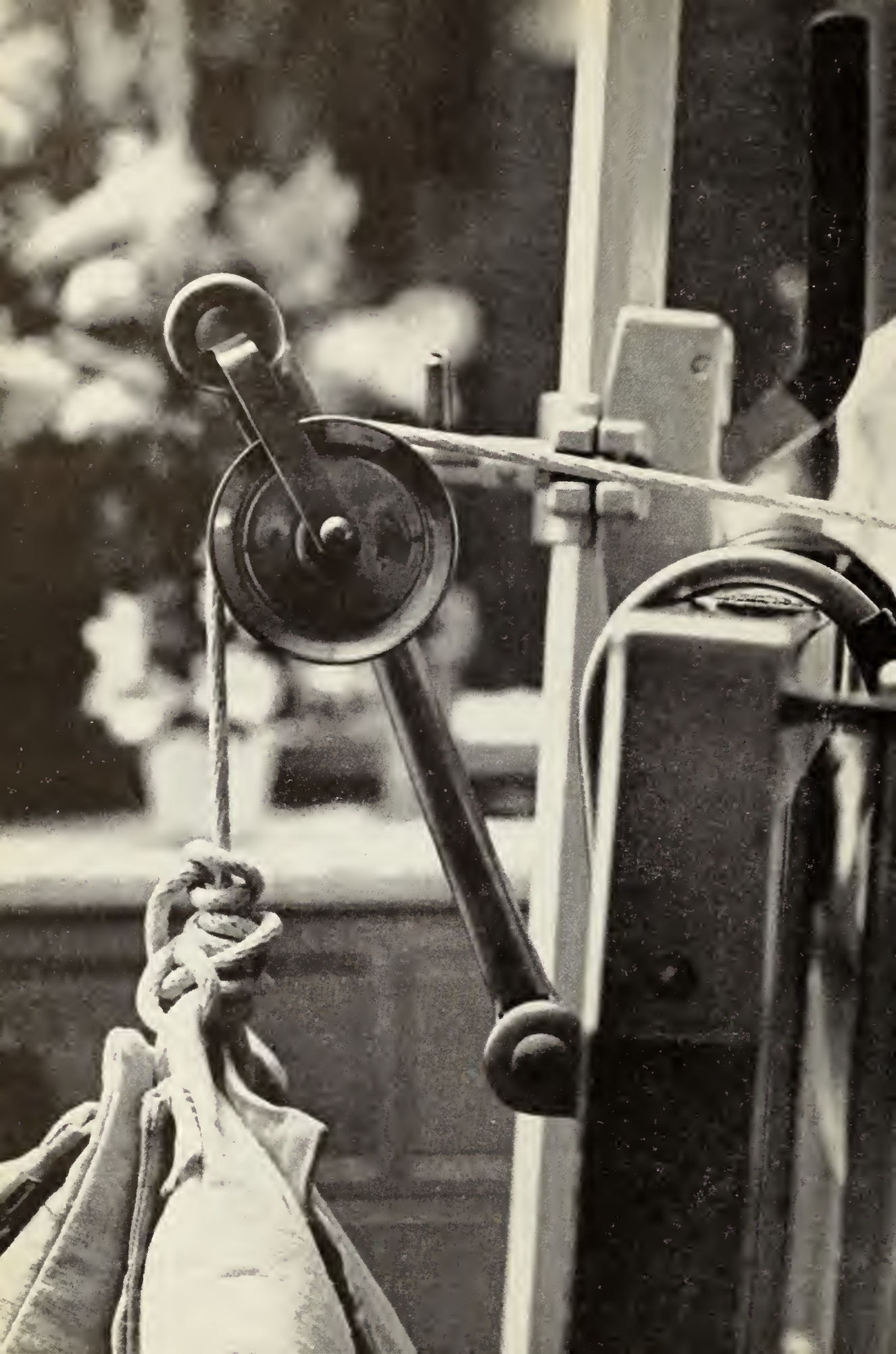
Contraindicated in the presence of marked hypertension and in cases of coronary or cardiovascular disease; also, in patients hypersensitive to Barbiturates or ephedrine-like drugs.

TOMORROW'S THERAPY TODAY
ERL
ESTABLISHED 1929

PIONEERS IN obesity

EASTERN RESEARCH LABORATORIES, Inc.
302 S. CENTRAL AVENUE BALTIMORE 2, MD.

*T. M. 4-65





TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of childbearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories **Philadelphia, Pa.**

Weighing on his mind, too

When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

This single-prescription, non-narcotic product, however, usually provides effective analgesia *and* helps put the patient's mind at ease.

Akron to Host Training Course For Emergency Care Aides

Akron will host one of 14 comprehensive training courses on emergency care and transportation of the sick and injured, scheduled this year under sponsorship of the Committee on Injuries of the American Academy of Orthopaedic Surgeons. Dr. Walter A. Hoyt, Jr., of Akron, is national committee chairman for the series of courses.

The courses are programmed to give practical and up-to-date information to ambulance attendants, policemen, firemen, safety engineers, nurses, rescue squads, and others who rescue and transport disabled persons. Instructors speak and demonstrate on a wide range of subjects, including resuscitation, cardiac massage, splinting of fractures, burns, and other medical emergencies. Extrication from crushed or overturned autos, aid to poison victims, and rescue from electricity are other subjects covered in the lectures and practice sessions.

The Akron course is scheduled for Thursday-Saturday, May 23-25, with Dr. Zouhair C. Yassine, 666 West Market Street, Akron 44303, as director.

Other courses are scheduled in New Orleans, April 3-6; Atlanta, June 5-8; Boston, June 17-20; Portland, September 4-7; Richmond, September 26-28; San Diego, September 30-October 3; New York, October 10-12; Denver, October date to be announced; San Antonio, October 24-26; Huntington, November 7-9; Lexington, November 14-16; Chattanooga, November 20 - December 1; and Miami, December 6-8.

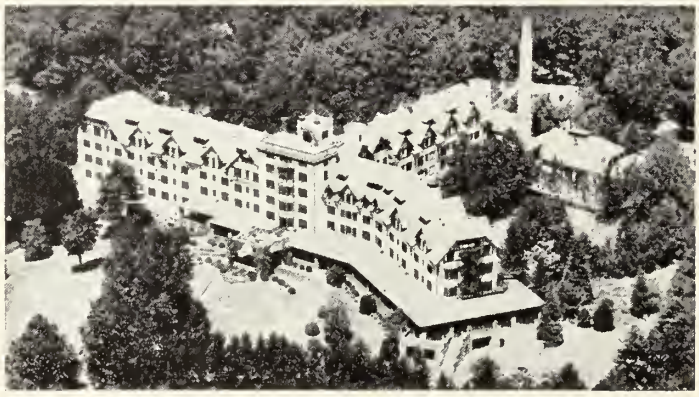
Application forms and registration information on any course may be obtained from the course director, or from Walter A. Hoyt, Jr., M. D., American Academy of Orthopaedic Surgeons, 666 West Market Street, Akron, Ohio 44303.

Andrews Grant Furthers Building Program at Western Reserve

Trustees of the Andrews Foundation have awarded $300,000 to the University Medical Center Development Program in Cleveland to support construction of the Mabel S. Andrews Wing of the Institute of Pathology on the Medical Center campus.

Work on the six-story addition is expected to begin by midyear. The project will be undertaken jointly with construction of Rainbow Babies and Childrens Hospital of University Hospitals of Cleveland. The new wing will connect to the children's hospital and to the Robert H. Bishop Building, the surgery-radiology center for the medical complex.

Appalachian Hall • ESTABLISHED 1916 Asheville, North Carolina



An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation. There are ample facilities for classification of patients

Insulin coma, electroshock, psychotherapy, occupational and recreational therapy are employed. The hospital is equipped with complete laboratory facilities, including electroencephalography and x-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town in the beautiful Smoky Mountain Range, an ideal location for rehabilitation.

WM. RAY GRIFFIN, Jr., M. D. MARK A. GRIFFIN, Sr., M. D.
ROBERT A. GRIFFIN, M. D. MARK A. GRIFFIN, Jr., M. D.

For rates and further information write APPALACHIAN HALL, Asheville, N. C.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient sodium excretion is greatly enhanced. Yet potassium loss is lo

The therapeutic action is smooth, and persists for a full 24 hou With Enduron you can prescribe convenient once-a-day dosa without skimping your patients on day-long thiazide effectivenes

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mo erate hypertension. A single 5-mg. tablet each day is ample most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine. .

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

)nce a day, every day

ENDURONYL®

ETHYCLOTHIAZIDE 5 mg. with
SERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

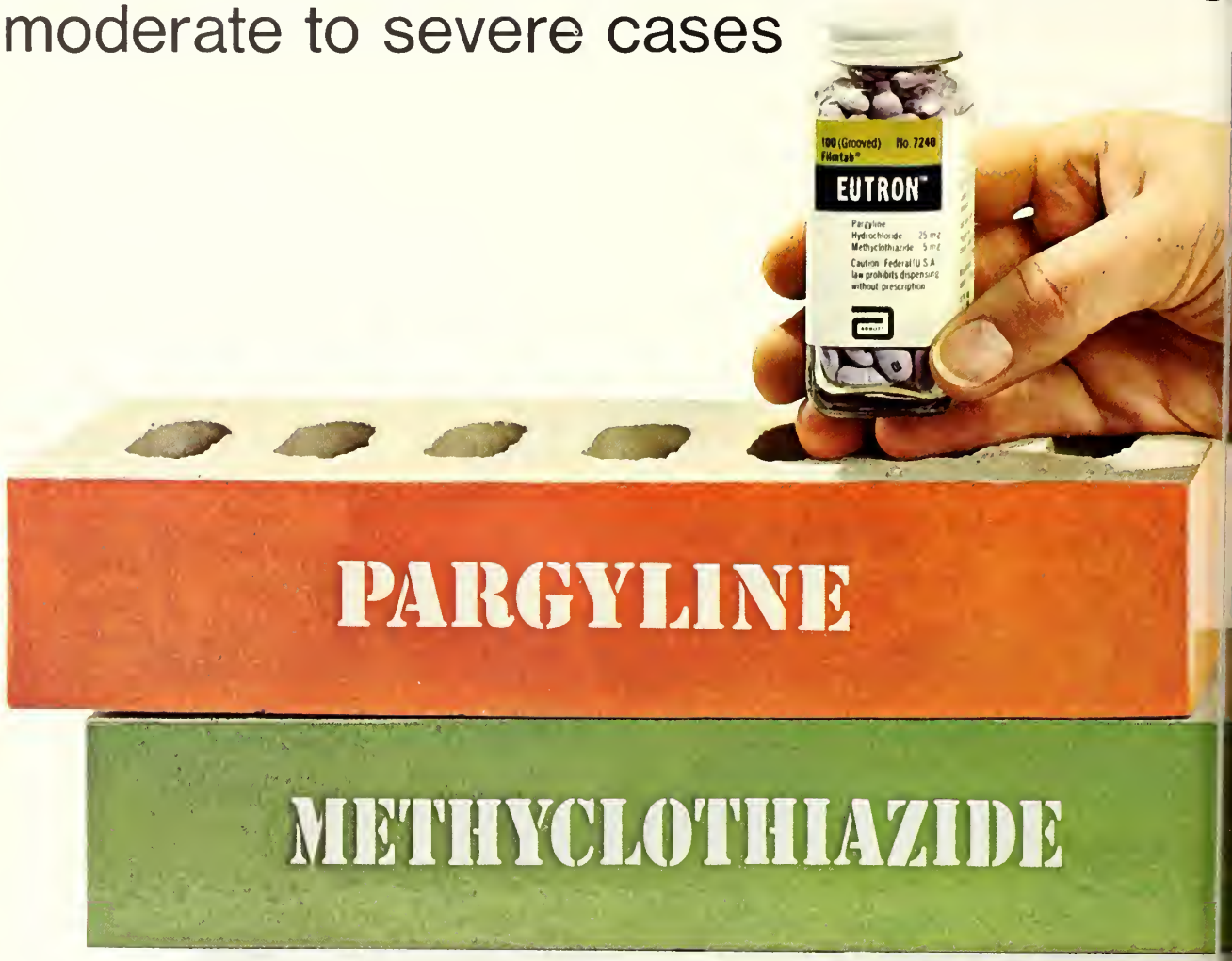
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether you patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings wer reduced from 112 pre-treatment to 90 post-treatment; *sitting* fro 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearl alike in all three body positions.

Use Eutron for managing your moderate to severe cases. I building blocks enhance each other; hence lesser doses often suffic

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg. with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVER



See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug.

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ABBOTT

TM-TRADEMARK

RESPONSIBILITY IN CITIZENSHIP

By PETER A. GRANSON, M.D.*

I STARTED WRITING THIS TALK many months ago. Many words and many thoughts flashed through my mind. I was so sure that I knew what I was going to say that the writing of this would be an easy affair. Well — it hasn't been easy. I knew that I did not wish to discuss the philosophy of medicine. I think that every doctor in this room realizes his responsibility to his patients.

What I would like to discuss with you this evening is the responsibility of citizenship — the responsibility that we have to this community and to this nation. We as physicians can no longer be monastic in our activities. We have been forced into the political arena. While this has not been to our liking, we are slowly beginning to realize that if we are to maintain the high quality of medicine in this country we must perforce become politically oriented. I do not feel that this is an imposition on the medical profession. It is an obligation. It is time we became actively interested in the stewardship of this nation. This stewardship demands active participation in the affairs of government by all of us.

Medicine Without Peer

Now, the freedom of medicine is being attacked from many sides. Living in a free society and practicing as free men, we have brought to this nation — yes, to the world — a quality of medicine without peer. The medical mecca is here. Here stream the physicians of the world for training. Our methods of practice, our research have brought comfort to the many corners of the world. This we have done as an association of free men without benefit of a check-off system and without compulsion.

History has shown that wherever the practice of medicine has been federalized or nationalized the whole country suffers. It is apparent that whenever socialism has taken over, that country is sapped of its strength, its initiative. This nation was settled by those seeking freedom from the paternalism of a supposedly solicitous government. The voice of the people dictated the role of the government.

Today our apathy is so great that we are beginning to lose control. Witness the summer anarchy that the citizens of this community and citizens of other major cities in this country have been subjected to. There appears to be an increasing acceptance of civil disobedience. I get the impression that our judicial system has gone too far in weakening our peace forces. There are those who are promoting the doctrine that when a law is broken society, not the criminal, is to blame. The responsibility of government and of the judicial system is to guarantee each citizen his primary civil right — that right to be protected from domestic violence.

The wage earner is being taxed into poverty. At retirement age he looks forward to a Social Security check which is but a small reflection of his efforts. Social Security is a fiscally irresponsible program, one that certainly does not allow anyone to approach the autumn of his life with any degree of dignity.

Responsibility to Community

These are but some of the reasons why we must become forcibly active. We have a responsibility to the community to be more than just doctors. We must be active citizens. We must help preserve this great nation: a nation where every man is free; where he has the privilege of going as far as abilities will take him.

I don't think that we have gone so far down the road to socialism that there is no turning back. The majority of our citizens are not looking for the rock candy mountain or the pie in the sky — they are not mentally obdurate — they are proud people, aggressive people. They do not need to be led by the hand of a solicitous bureaucracy. They do not need to be told what is good for them. They need not be talked down to by their representatives. They deserve the right to fend for themselves. They must be given the opportunity to prepare for their own future within the framework of our laws.

Above all we must demand fiscal responsibility from our government. We must demand morality and honesty, and the voice of all the people must be heard. The problems are many. The solutions require active participation of an informed citizenry, and that includes the medical profession.

There was no special mold for this nation, instead a crucible was used. And into this crucible was mixed the customs, the language of Europe; but

*Dr. Granson is 1968 President of the Montgomery County Medical Society. This article is the text of his Inaugural Address delivered at the Society's 119th Inaugural, January 19, 1968, and reprinted from the Society's Medical News.

most important, into this fiery amalgam was mixed the desires for freedom from religious persecution, the right to strive for the betterment of one's lot unhampered by custom, race, color, or creed. From all of this emerged a creature unique, an American. It is for this man we have the responsibility. This is not a little man. No American is a little man. He is a giant among men and he must remain so. He must be the master of his destiny.

Government by Bureaucracy

Presently our government, with the aid of sociologists and economists, feel that we are not capable of giving our lives proper direction. We need to be told how, when, and where. We send our representatives to the legislative branches of our government expecting them to enact the laws that will govern us. In truth, they do only half a job. Even a cursory examination will show that we are being governed by regulations — regulations written by members of bureaus and not our elected representatives.

All this we bear with only an occasional murmur. The candidates that we elect to public office must be our servants and we must be their jealous masters, because our concern must be for the future of this great nation. These are not platitudes, these are realities of life. Freedom is for the brave and the resolute. Every man and woman has a contribution to make and what we do now as citizens will shape the future for our children and our children's children. We cannot — we must not turn our backs on the responsibilities of citizenship.

Many Laboratories Seek Voluntary Accreditation for Animal Care

More than 100 animal laboratory facilities have now been site visited by the American Association for Accreditation of Laboratory Animal Care and 80 have been fully accredited, although the AAALAC accreditation program has been in full operation for only approximately two years.

It was further reported that at the end of 1967, 122 institutions had formally applied for accreditation. Site visits and evaluation of animal care programs have been completed for 104 institutions. Sixty-six were accredited initially; 26 were provisionally accredited, and 12 were denied accreditation. Thirteen of the provisionally accredited and one nonaccredited institution later corrected their deficiencies and were fully accredited.

AAALAC was founded in 1965 by 16 organizations interested in laboratory animals, among them the American Medical Association.



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa.

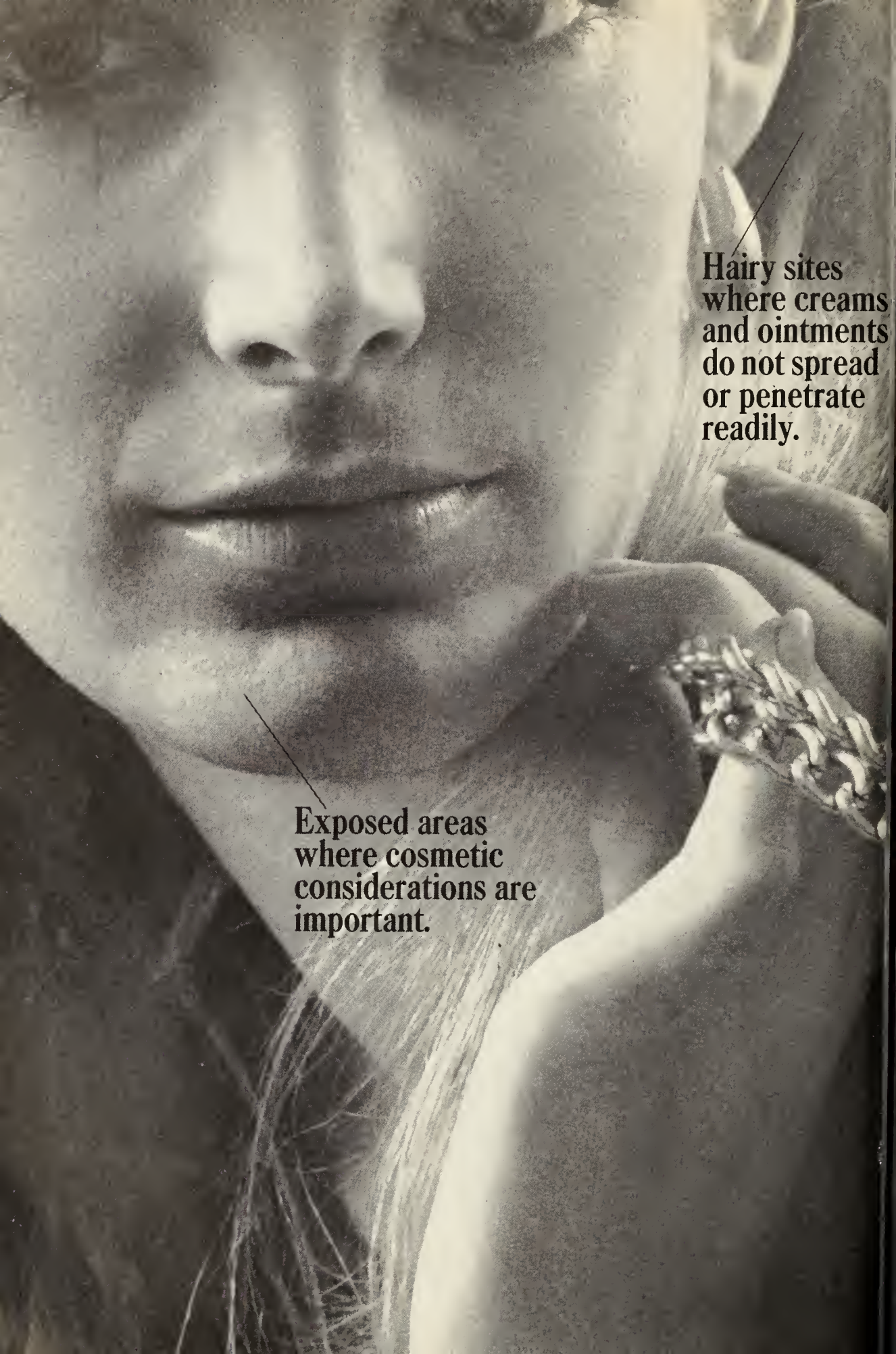
In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

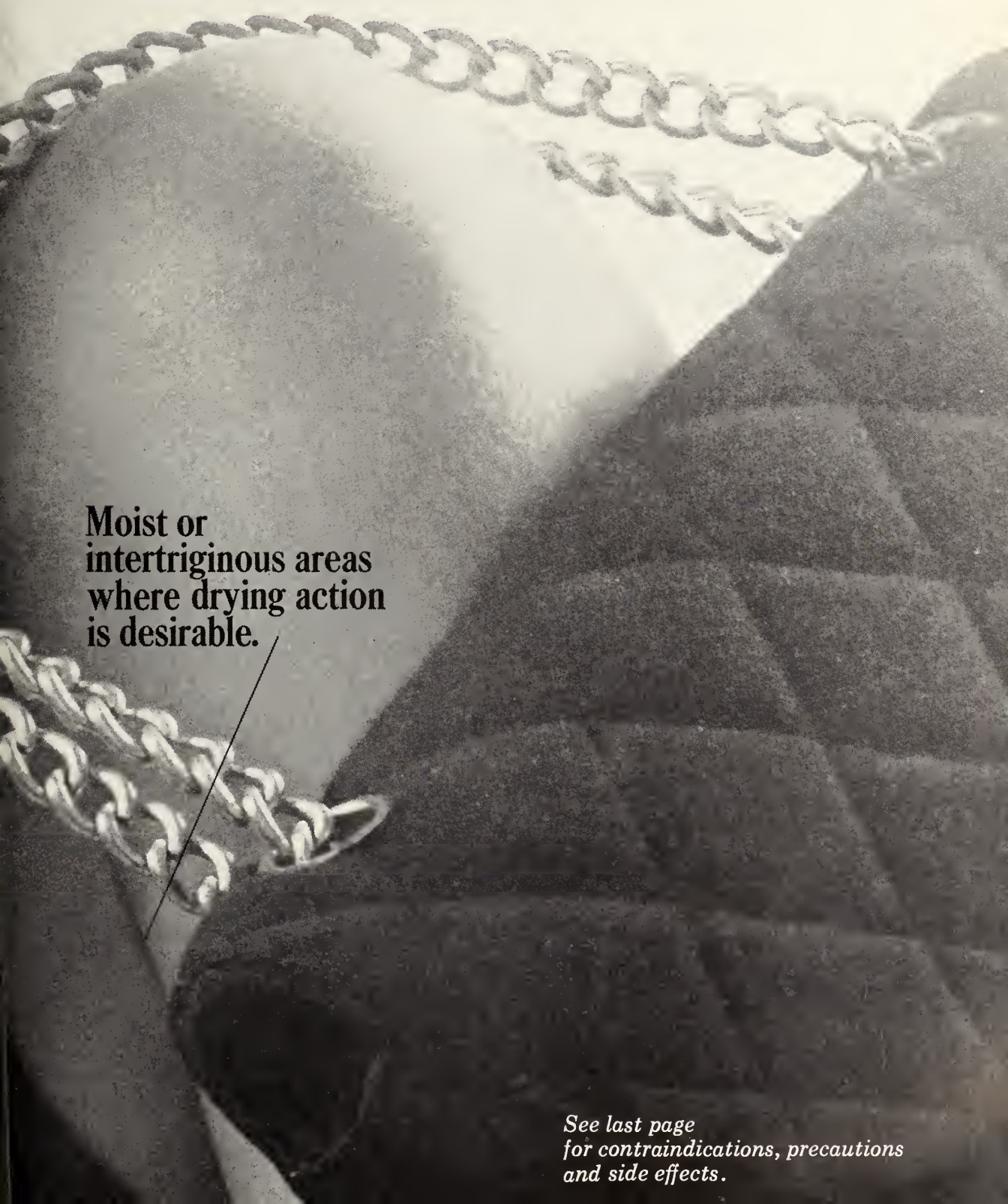
ROER ROERER

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Fort Washington, Pa.


Hairy sites where creams and ointments do not spread or penetrate readily.
Exposed areas where cosmetic considerations are important.

An invisible topical

for many dermatologic problems



Moist or intertriginous areas where drying action is desirable.

See last page for contraindications, precautions and side effects.

Structurally unique topical steroid in propylene glycol vehicle produces rapid response in many dermatoses.

Synalar Solution produces rapid antiinflammatory, antipruritic action through its unique topical corticosteroid, fluocinolone acetonide. The propylene glycol vehicle provides additional benefits for therapy at problem sites where it is difficult to achieve contact between the lesion and medication – or where creams or ointments may make the lesions worse. Synalar Solution has proved particularly valuable in the symptomatic treatment of seborrheic dermatitis of the scalp, nasolabial folds, eyebrows, ears, and in flexural folds such as the axillae, inframammary, umbilical and anocrural areas. It has also been reported to achieve excellent results in the adjunctive management of atopic dermatitis, contact dermatitis, neurodermatitis, nummular eczema, psoriasis, and sweat retention syndromes in these problem sites.

Penetrates the hairy sites.

In many areas of the body, hair gets in the way of treating the underlying dermatitis. The propylene glycol vehicle of Synalar Solution permits penetration and dispersion at sites where creams and ointments do not readily penetrate. May be applied without matting of hair.

Ideal for moist or intertriginous areas.

Propylene glycol is strongly hygroscopic and is especially useful where sweat retention is a problem. Its low surface tension permits easy spreadability in difficult-to-treat body areas. A number of studies have also shown that propylene glycol has inherent antimicrobial activity.



Cosmetically acceptable for exposed areas.

The propylene glycol vehicle of Synalar Solution possesses many useful cosmetic properties. Clear and greaseless, it is not sticky or messy, will not stain clothing or skin. In exposed areas of the body where cosmetic appeal is important, Synalar Solution shows nothing but results.

Economical—a little goes a long way.

Because of the properties of propylene glycol and the milligram potency of fluocinolone acetonide, a small quantity of Synalar Solution goes a long way. Also, the prescription price of a 20 cc. plastic squeeze bottle of Synalar Solution is surprisingly low. Thus, your patients obtain economy with the proved efficacy of a potent, truly advanced topical corticosteroid.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

Availability: Synalar (fluocinolone acetonide) Solution 0.01% in a propylene glycol vehicle with citric acid as preservative. 20 and 60 cc. plastic squeeze bottles. *Also available:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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Synalar®
(fluocinolone acetonide)
Solution
0.01%

An invisible topical



OSU Names Building in Honor Of Former Medical Dean

Ohio State University has named a campus building in memory of a distinguished figure in medical education. The university's Board of Trustees approved the name of "William J. Means Hall" for the building which housed the Ohio tuberculosis medical services at 466 W. Tenth Avenue in Columbus.

The name honors the late Dr. Means, who served as first dean of the College of Medicine from 1914-16. Before establishment of the College he had been professor of surgery for seven years and dean for five years at Starling-Ohio Medical College of Columbus. He was professor of surgery at Ohio Medical University, Columbus, from 1892 to 1906.

After merger of Starling-Ohio with Ohio State, which Dr. Means was credited with bringing about, he served also as first chairman of the Department of Surgery from 1914-16. He died in 1929 at the age of 76.

Naming of the building was proposed by Dean Richard L. Meiling on behalf of the College of Medicine. Legislative transfer of the building from the Ohio Department of Health to the university became effective on January 1.

Two sons and a nephew of the first dean, all now holding professor emeritus status, have been prominent as faculty members of the College of Medicine. The sons are Dr. John W. Means, emeritus professor of surgery, and Dr. Hugh Means, emeritus professor of radiology and former department chairman. The nephew is Dr. Russel G. Means, Sr., emeritus professor of otolaryngology and former department chairman. All three reside in Columbus.

Occupational Therapy Association To Meet in Cincinnati

Human Development will be the theme of the Ohio Occupational Therapy Association's Annual Conference, scheduled at the Terrace Hilton Hotel, Cincinnati, Friday and Saturday, May 17 and 18.

Dr. Bruno Bettelheim, University of Chicago's Orthogenic School, will be guest lecturer, and will give a total of six lectures — three each on Friday and Saturday. The speaker's focal point the first day will be on pressing problems of development and how they relate to children, adolescents, and adults. The second day he will lecture on behavior modifications emphasized within the three age groupings. He will briefly touch on research he and his associates are engaged in at the University of Chicago.

Further information may be obtained from Mrs. L. Pommerer, 5113 Colerain Avenue, Cincinnati 45223.



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Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB



Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q.* 4 *h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA **SINUTAB**® FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

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Comments on Current Economic, Social And Professional Matters

MEDICAL NEWS SECTION OF JAMA AN OUTSTANDING SERVICE

It has been estimated that the "average" practicing physician spends from six to eight hours every week in reading scientific papers and medical journals.

But the continuing advances in medical science have become so vast that even if a physician abandoned his practice and spent all his time reading medical literature, it would be impossible for him to cover it all.

That's why the service performed by the American Medical Association's Medical News Department fulfils such a vital role in medical communications today. Its product, appearing each week in the "Medical News" section of *JAMA,* is 14 pages of concise, up-to-the-minute, authoritative news of research and medical meetings.

Because most practicing physicians do not have time to attend more than four or five medical meetings a year, the Medical News staff, comprised of seven science writers and editors, goes where most physicians can't.

The staff travels throughout the United States annually covering approximately 160 scientific meetings considered especially significant. Roughly, 85 per cent of these have a direct relationship to medicine. The remainder deal with physics, biochemistry and other closely related scientific disciplines.

Since an increasing amount of research is being done in laboratories and clinics financed by the federal government and since more and more decisions being made in Washington have a direct and profound effect on research, one member of the staff is assigned to the Washington Office. He also covers the eastern seaboard.

From its onetime limited role of merely reporting professional items of interest, the Medical News Department has grown steadily in recent years to meet its obligation of keeping the practicing physician informed on what is taking place on the medical scene.

Special care is taken to select significant material, and present it in a conservative manner. Its articles never draw conclusions.

In our opinion, its means of communication is one more outstanding service the AMA is providing busy physicians, and one more reason why physicians should support the AMA.

SECRECY IN DRUG EFFICACY REVIEW IS GESTAPO MEDICINE

One of the greatest factors in America's world leadership in medicine is the complete absence of secrecy in medical developments. So-called secret remedies, secret treatments, and secret cures are offered only by the quack and charlatan.

For this reason, the profession must concern itself deeply with government secrecy in medicine. We refer to the National Academy of Science-National Research Council pronouncement in regard to a panel of experts which held bioflavonoids to be ineffective. According to the pronouncement, names of the panel of experts shall remain secret.

There are 29 panels of "experts" studying the efficacy of more than 2,500 drugs. Their findings are to be widely publicized while the experts remain immune to scientific challenge or inquiry. The magnitude of such secrecy is alarming.

The medical profession, for the benefit of medicine and medicine's patients, has everything to lose if free and open scientific pronouncements, discussions, and recommendations are to be denied. This applies as well to the identity of the "experts" arriving at such conclusions. Just as medicine has the ethical right and moral responsibility to judge and evaluate a medical devolopment, so has it the right and responsibility to judge the developers.

In the interest of preserving free, open, independent, and rapid interchange of scientific data and knowledge, medicine is unalterably opposed to such secrecy, whether it be governmental or nongovernmental.

In the interest of preserving their personal ethics and professional integrity, members of these 29 advisory panels should demand that their identities be made public.



Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, Equanil® often may play an important role in medical and surgical aftercare.

ndications: For use in management of anxiety and tension occurring lone or as accompanying symptom complex to medical and surgical sorders and procedures. Though not a hypnotic, fosters normal eep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported.

One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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Equanil®

(meprobamate)

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Professionally posed.



The Physician's Bookshelf

The Doctor's Perspective: Physicians View Their Patients and Practice. Published by the Press of Case Western Reserve University, the book reports results of a detailed study of 178 practicing physicians conducted by a team consisting of two physicians and two psychologists from the University Medical Center. They are Amasa B. Ford, M. D., assistant professor of medicine; Ralph E. Liske, Ph. D., John D. Denton, Ph. D., and Robert S. Ort, M. D., formerly of the institution, but now a resident in psychiatry at Montefiore Hospital, New York.

Dr. Bernard V. Dryer, Cleveland, recently had his new novel about modern medicine published by Simon and Schuster, Rockefeller Center, New York. The book is titled *The Torch Bearers* and the publishers reported that it has been chosen as a March selection of the Literary Guild. The book also will be published in several foreign countries.

The central character of *The Torch Bearers is* Dionisio Mayoso Marti, M. D., a refugee Cuban OB-Gyn physician practicing in Puerto Rico. Dr. Mayoso's activities in the story take him through some dramatic aspects of research and practice in a major New England Medical Center.

Many readers will remember Dr. Dryer's last novel, *The Image Makers,* the story of an American plastic surgeon in France and North Africa. The author has been an active participant in medical organization work and has served on many local committees. He was the study director of the Joint Study in Continuing Medical Education, a national research project sponsored by the American Medical Association and other professional groups. The result was the monograph *Lifetime Learning for Physicians,* sometimes known as the Dryer Report.

Cleveland Physician Heads National Orthopaedic Surgery Group

Dr. Charles H. Herndon, head of the Division of Orthopaedic Surgery at University Hospitals, and Rainbow Professor of Orthopaedic Surgery at Case Western Reserve University School of Medicine, Cleveland, became president of the American Academy of Orthopaedic Surgeons which met in Chicago recently.

He succeeds Dr. Francis E. West, San Diego, California, who held office during the past year.

Dr. Herndon's other professional distinctions include his election to the Presidency of the Orthopaedic Research Society, in 1947; Presidency of the American Board of Orthopaedic Surgery, in 1964; Chairmanship of the Committee on the Skeletal System of the National Research Council, National Academy of Sciences, since 1962; and appointment as associate editor of the *Journal of Bone and Joint Surgery,* from 1955 to 1961.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during February. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Butler
Donald G. Fisher, Hamilton
Tiberius E. Remotigue, Hamilton

Clark
Sally A. Abbott, Springfield

Cuyahoga
Wladyslaw Topolnicki, Cleveland

Delaware
George W. Parker, Delaware

Hamilton
J. Wesley Alexander, Cincinnati
Walter Lyon, Cincinnati
Clarice D. Reid, Cincinnati
George S. Shields, Cincinnati

Jefferson
Milo R. V. Paradis, Steubenville

Lake
Jack F. Bailey, Mentor
Bertram H. Cochran, Mentor

Lawrence
Jose O. Fleites, Ironton

Logan
Donald G. Wyse, West Liberty

Mahoning
Bertwin E. Einfalt, Youngstown
Jose I. Gonzalez, Youngstown

Muskingum
Pedro A. Corrons, Zanesville
Joseph S. Safko, Zanesville

Portage
Amador P. Rasalan, Kent

Ross
F. Ponce DeLeon, Chillicothe

Shelby
Roger D. Jenkins, Jackson Center

Trumbull
Catalina R. Isalque, Warren
Ulises Isalque, Warren
Irvine G. Milheim, Jr., Warren
Domingo P. Villiereal, Warren

Tuscarawas
Robert L. Gerber, Sugarcreek
Dale R. Kollman, Tuscarawas

Williams
Lenin Rivera-Nieves, Pioneer

Three-Days-of-Cardiology Course Scheduled for Cleveland

Cleveland will be host to a postgraduate course entitled "Three Days of Cardiology," September 25-27, 1968. The Cleveland course, "Problems Affecting the Cerebral, Renal, and Peripheral Circulation," will be directed by Ray W. Gifford, Jr., M. D., and Victor G. DeWolfe, M. D., and is cosponsored by the Ohio State Heart Association, the Heart Association of Northeastern Ohio, and the Cleveland Clinic Foundation.

Another Three-Days-of-Cardiology course will be given May 13-15 in Hamilton, Ontario, Canada, under the title "Etiology and Treatment of Thromboembolic Disease," directed by J. Fraser Mustard, M. D., W. J. Walsh, M. D., and John B. Armstrong, M. D., cosponsored by Canadian Heart Foundation and McMaster University.

Registration Fees for the courses are $50 for Members and Fellows of the Council on Clinical Cardiology, and $85 for nonmembers. Registration forms may be obtained from the Department of Medical Education, American Heart Association, 44 East 23rd Street, New York, New York 10010.

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Each tablet contains:

Potassium Iodide . . . . . 195 mg.
Aminophylline . . . . . 130 mg.
Phenobarbital, Caution: May be habit forming . . . 21 mg.
Ephedrine HCl . . . . . 16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

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MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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AMA's Department of Investigation . . .

Constant Vigilance Against Charlatans Is One Way the AMA Is Serving the Profession and Protecting the Public Health

WHEN the American Medical Association was founded 121 years ago as a means of propelling American medicine out of its then "Dark Ages," one of its chief goals was to protect the public from health quacks, charlatans and pretenders.

If those concerned early-day physicians could somehow be given a miraculous glimpse into the 1960's, they might be disheartend, but perhaps not surprised to find that their lofty goal of driving quackery into everlasting oblivion has not yet been reached.

Although great strides have been made against quackery through the years, the battle is far from won. Because of man's inherent weaknesses, quackery most likely never will be completely uprooted. Unfortunately for both man and medicine, the glib, fast-footed quack too often is as adaptable as a chameleon in his relentless, yet often lucrative struggle for survival.

Spearheading the unremitting attack against the many ruthless forms of health quackery that endanger health and bilk victims of an estimated billion dollars a year is the AMA's Department of Investigation, which has many powerful allies in its vigilant quest.

Allies in Vigilance

Chief among them were the Food and Drug Administration, Post Office Department, Federal Trade Commission, National Better Business Bureau, American Pharmaceutical Association, American Cancer Society, Arthritis Foundation and numerous other public and private agencies, including all law enforcement bodies.

Serving as a clearing house for information on quackery, pseudo medicine and nostrums, the Department of Investigation's staff of 11 persons has meticulously amassed and catalogued the most extensive files available on quackery. These files are used daily in exposing quacks.

Since quacks and other medical pretenders are quite clever and so changeable in their methods, the staff is constantly on the alert for new guises as well as the old. Although the department has no law enforcement powers, much of the information it gathers, through state and local medical societies and through its own initiative, is used by federal, state, local, and foreign law enforcement agencies and state licensing agencies to prosecute offenders.

One of its key roles is to alert regulatory agencies when circumstances point to the likelihood that the laws which such agencies are obliged to enforce are being violated.

Department Created

The department, created in 1906, is the brainchild of the late Arthur Cramp, M. D., who, as associate editor of the *Journal of the American Medical Association,* started what was then called the Department of Propaganda for Reform in Advertising of Patent Medicines. Doctor Cramp was a most effective campaigner.

In that era, inquiries concerning quackery came primarily from physicians. That was the heyday of nostrums blatantly promising cures of diabetes or cure and alleviation of such conditions as tuberculosis, venereal disease, and diphtheria. Most such nostrums, through regulatory action, have faded from the scene, being replaced by more timely "wonder cures."

Today's "merchants of menace" have adapted to the times, finding that their livelihood is greatly enhanced by such phony, but readily saleable wares as baldness cures, sea water products, insomnia treatments, breast developers, cancer cures, useless vitamins, height increasers, all-purpose spinal adjustments and cures for the tobacco habit.

Since health education of the public is mandatory to thwart exploitation of the fearful, sick, and the retarded, many of the department's efforts in recent years have been concentrated in this area with increasingly productive results. Widely diversified literature, exhibits and films — all part of this positive AMA program — have spurred greater public understanding of quackery and its evils. Today the majority of the thousands of inquiries annually directed to the department originate from the public.

Numerous quacks have been driven out of their thriving "practices" because of greater public understanding and coordinated efforts on the part of the AMA, medical societies and agencies equally concerned with the problems. Many of their phony products no longer are marketable. Other quacks,



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although still plying their trade, have been forced into exile by the close watch of regulatory bodies.

Cancer "Cures" Exposed

Cancer "cures" such as the liquid and pills concocted by the late "Dr." Hoxsey, "gregomycin," which was conveniently unearthed from the backyard of another medical pretender and the more recent "krebiozen" have disappeared from the scene because of professional surveillance and ensuing regulatory action.

Thanks to quick action by the AMA, the Ohio State Medical Association and the Cleveland Academy, along with regulatory bodies, another alleged cancer cure, the "Rand vaccine" was halted before it had a chance to "make a name for itself" by creating false hopes. After initial publicity in the lay presses, cancer victims from throughout the world flocked to Cleveland to obtain this substance. Another potential "krebiozen" fiasco was avoided when a federal district court ultimately barred both the manufacture and distribution of the substance.

Hard times are falling on other impostors through similar action, such as Antonio Agpaoa, the self-styled "psychic surgeon" of the Philippines who has specialized in treating Americans. Alerted by the AMA, the U. S. State Department, Philippine Medical Association and government agencies are keeping a close eye on the situation. A group of more than 100 Detroit hopefuls recently visited Agpaoa. His "treatment" was branded as a "cruel hoax" upon their return.

Squelching the "Imports"

Inroads also have been made against "dipyrone," a dangerous drug being dispensed across the border by Mexico physicians. Several deaths occurred among arthritis sufferers in several Southern states before Louisiana physicians, the AMA and others could determine the cause and issue public warnings.

In Tijuana, Mexico, still more cancer "cures" have sprouted. Despite public warnings, however, a ready supply of hopeful patients is available. As a "service" to these patients, free bus service from California is provided. Their cancer treatment in Tijuana? Drugs found to be worthless by U. S. authorities.

In the meantime, the AMA, through the Department of Investigation and other arms, is utilizing every weapon at its command to halt the spread of quackery.

The individual physician can do his part by keeping in touch with the Department of Investigation and making good use of the services and the educational literature which it has developed for the benefit of the profession and the public.

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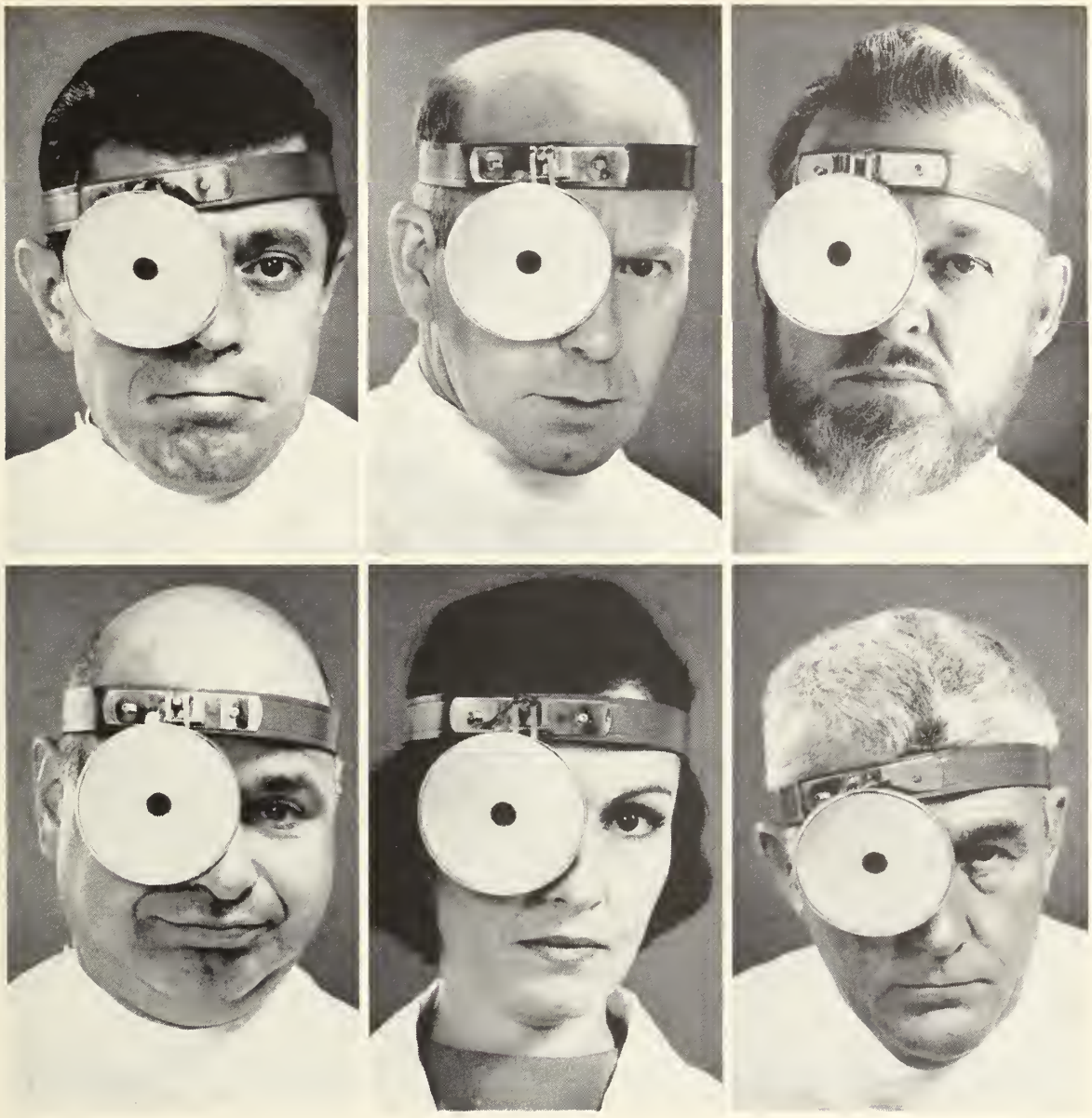
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COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

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"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.



Grounds...for Regroton®

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reserpine 0.25 mg.



when you want to provide the combined benefits of two accepted agents in the treatment of mild to moderate hypertension. (Contraindications: history of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.)

when you want to prescribe therapy that is generally well tolerated.

(However, adverse reactions may occur. For a complete listing, please refer to the full prescribing information which is summarized below.)

when your patient wants an easy-to-remember and reasonably priced regimen. (One tablet a day usually costs about a dime.)

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue 1 week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn. **Precautions:** Antihypertensive therapy with Regroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. **For details, see complete Prescribing Information.** (B)46-600-B

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Regroton® **Geigy**

Leaflet on Sodium Restricted Diet Available from Heart Groups

A new leaflet based on the booklet, "Your Mild Sodium-Restricted Diet" which the American Heart Association published in 1958, has now been made available to physicians. Like the booklet, the leaflet is available to patients only on a physician's prescription, or to those who already have received the booklet.

The simplified leaflet, entitled "Sodium Restricted Diet — Mild Restriction," contains the same diet but is less detailed than the 48 page booklet from which it was adapted. In addition to the daily diet plan and food lists for 1,800 calories or less, the leaflet contains important information on sources of sodium, and on shopping, cooking, seasonings, and eating out. Unfolded, the leaflet becomes a 20 by 10 inch chart for posting in kitchens.

Prepared by the American Heart Association in cooperation with the Heart Disease Control Program, U. S. Public Health Service, and the American Dietetic Association, the leaflet may be obtained by physicians, nurses, dietitians, nutritionists, hospital, and nursing home administrators, medical societies and local health departments through Heart Associations in their communities. Central contact in Ohio is the Ohio State Heart Association, 10 East Town Street, Columbus 43215.

Physicians in Mental Hygiene Field Announce Meeting

The Association of Physicians of the Ohio Department of Mental Hygiene and Correction announced a meeting to be held at the Toledo State Hospital, Toledo, on April 5, with Joseph E. Duty, M. D., superintendent, as host.

On the program are the following speakers and topics: Edwin Dunlop, M. D., director of the Fuller Sanitarium and Foundation and Fellow of the American Psychiatric Association, "Effective Management of Depression"; William Easson, M. D., chairman and professor of psychiatry of the Medical College of Ohio at Toledo, "The Dying Patient"; and Mrs. Rosa Marie Moody, A. C. S. W. at Toledo State Hospital, "Affection Treatment in Psychiatric Social Work." Discussions follow each paper as presented.

Included in the program is also a short business session of the Association which is headed by Julius Nemeth, M. D., Woodside Receiving Hospital, Youngstown, president; and Virginia S. Edwards, M. D., 347 Lexington Avenue, Mansfield, secretary-treasurer.

Plans are being formulated for the quarterly meetings of the group scheduled for July 12 at the Ohio State Reformatory in Mansfield and for October 4 in the Columbus area.

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IMPOTENCE



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(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

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PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
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*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily
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Bottles of 100, 500, 1000.

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Each red tablet contains:
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EXTRA HIGH POTENCY
Each orange tablet contains:
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Thyroid Ext. (1 gr.) . . 64 mg.
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Thiamine HCL . . . . . 10 mg.
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Available:
Bottles of 60, 500.

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WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
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Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
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Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Panthothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

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also available with ESTROGEN

Android —E
Each Tablet Contains:
Methyl Testosterone . . . . . 2.5 mg.
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INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRAINDICATIONS:** See Android Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.



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...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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phosphorated carbohydrate solution
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for topical antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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but can she keep it off?
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That's why Abbott offers you a pill plus a program.

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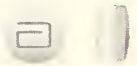
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For patients who can't take plain amphetamine

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60 mg. Sodium Pentobarbital



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The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



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Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



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A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



801444

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

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Ohio Had More Than Its Share Of Catastrophes in 1967

The 1967 loss of life in national catastrophes has taken a sharp dip below the annual average for the past ten years. The latest records indicate nearly 1,300 persons were fatally injured last year in catastrophic accidents (accidents taking 5 or more lives). The annual average for the past decade had been pegged at about 1,400 lives in the United States, (excluding Alaska and Hawaii).

There were nine major catastrophes during 1967, each of which took at least 25 lives, and together, resulted in over 400 fatalities. Five of these disasters involved accidents in civil aviation, the most serious of which occurred on July 19, when a scheduled plane and a small private aircraft collided near Hendersonville, North Carolina, producing a death toll of 82 lives.

The second heaviest loss of life was in the November 20 crash of a scheduled airliner near the Cincinnati, Ohio, airport (on the Kentucky side of the river), which took 69 lives. The three other disasters involving commercial aircraft were: the explosion of a scheduled plane during a storm near Kenton, Ohio, on March 5, resulting in 38 fatalities; a collision of a scheduled plane with a private craft in the air near Urbana, Ohio, on March 9, which fatally injured 26 persons; and a plane crash near Blossburg, Pa., on June 23, which caused 34 deaths.

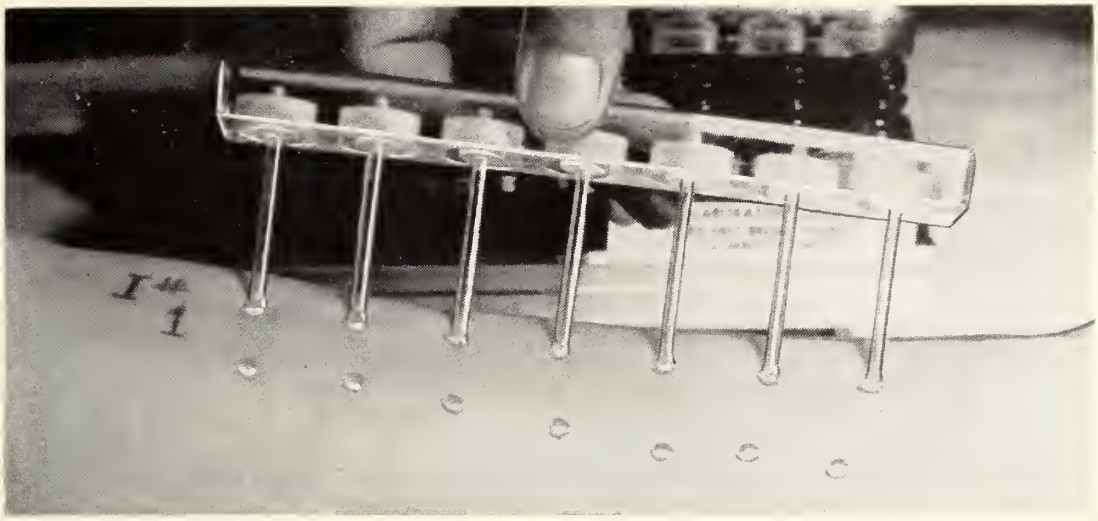
Tornadoes devastated several areas in northeastern Illinois on April 21, accounting for 55 fatalities. A suspension bridge between Pt. Pleasant, W. Va., and Kanauga, Ohio, collapsed during heavy traffic on December 15, taking 46 lives, (including those missing). Thirty-eight persons died in a fire which swept a prison camp barracks at Berrydale, Fla., on July 16; and 25 lost their lives in a fire which occurred in a penthouse restaurant at Montgomery, Ala., on February 7.

There was a heavier loss of lives in civil and military aviation catastrophic accidents in 1967 than in 1966, and fatalities from fires and explosions were also somewhat more frequent. The increased death toll in these types of accidents was offset by the smaller number fatally injured in motor vehicle accidents, water transportation and natural catastrophes.
—*Metropolitan Life Insurance Company.*

Symposium on Dextrans

The first International Symposium on Dextrans will be held at Galveston Island, Texas, on Sunday and Monday, May 19 and 20. The title is "Current Concepts of the Basic Actions of Dextrans and Their Clinical Application in the Cardiovascular and Related Fields." Write the Texas Heart Association, P. O. Box 25041, Houston, Texas 77005.

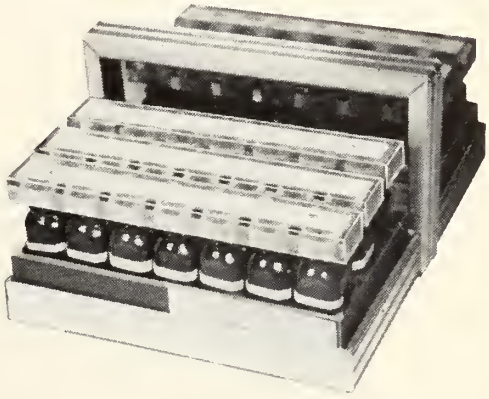
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A fast clinically proven Allergy test and therapy service for *Busy Physicians*

This easy three-step allergy test kit contains 42 Allergens, clinically selected. The new testing technique allows you or your nurse to apply 7 different drops of potent allergens to the skin at one time. It's economical, fast . . . allowing you to manage allergy diagnosis with minimum time and cost.



TREATMENT BY Rx

The physician's prescription of therapeutic antigens for the individual patient are carefully compounded in our laboratories by following the clinical diagnostic indications of skin test and history reports submitted.

The prescription treatment sets are sent to you in four vials of graduated dilutions to support a conservative dosage schedule and to permit a dosage adjustment if indicated by your patient's sensitivity.



STOCK TREATMENT SETS AVAILABLE

When clinical diagnosis indicates a clear seasonal pattern of sensitivity you may desire a combination of the most prevalent antigens occurring in that season. You may choose from these stock treatment sets; Ragweed Mix, Grass Mix, Mixed Mold Treatment, Dust Treatment, Animal Dander (dog, cat or horse). Stinging Insect Mix.

SINGLE VIAL Rx

Each vial is made to the individual doctor's prescription of antigens, creating a constant control of therapy, reflecting patient reaction and tolerance. This enables the doctor to adjust dilution and add or delete antigens with each vial as indicated by patient's reaction. ALO maintains a permanent, fast referrence patient record of each prescription.

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Western Reserve Offers Doctors Personalized PG Courses

Practicing physicians in northeast Ohio have been offered a unique educational service by Case Western Reserve University School of Medicine in the form of part-time custom-tailored postgraduate courses.

An invitation for participation has been issued in the form of a booklet mailed to physicians in the vicinity of Cleveland. The booklet lists daily hospital conferences and lectures at the School of Medicine and the associated University hospitals and facilities. Any physician may attend these without charge.

In addition, the booklet suggests three ways the doctor seeking more individualized instruction can get the kind of help he wants at a nominal tuition charge:

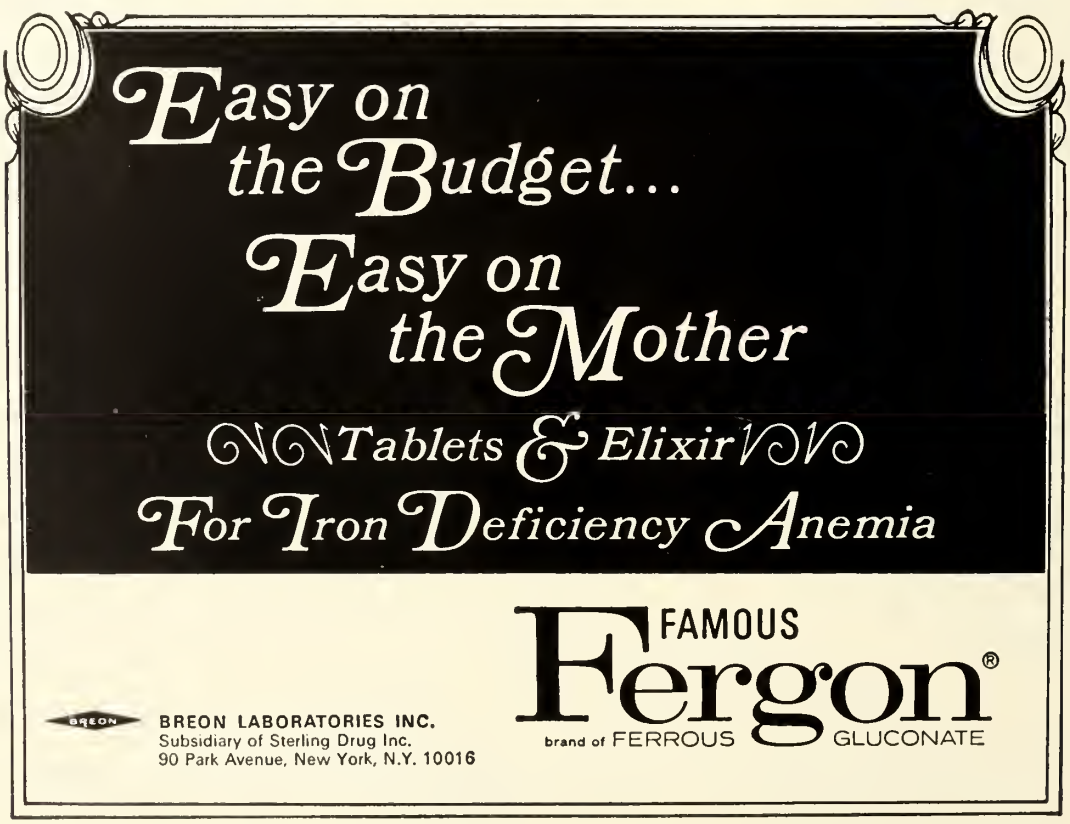
1. Personal advice from a faculty member. If the doctor wants to fill gaps in his knowledge of a particular field of medicine, he can meet with a faculty member who is expert in that field, and get such help as a suggested reading list or opportunities to participate in the daily clinical conferences held at the University's teaching hospitals in that specialty.

2. A course in the School's regular curriculum. The CWRU medical school curriculum, unlike the traditional program, has been reorganized into courses on organ systems of the body. This makes it possible for a returning student to take one course and get a comprehensive medical view of that system from a team of professors whose specialties range from fundamental biology to highly practical clinical applications. For the postgraduate student, such a course amounts to both a "refresher" and a survey of new developments since he left school.

3. An individualized course of study. Special problems encountered in his practice, for which the physician-student seeks instruction, could be discussed with a faculty member, who would work out an individualized course of study — lasting two weeks to three months — including private daily conferences with an assigned preceptor, and participation in the School's clinical service.

On some medical problems that doctors in general practice encounter all the time — for instance, "Infections, Immunity, and Antibiotics," "Arthritis and Rheumatism," "Endocrinology and Metabolism," etc. — the Office of Postgraduate Medical Education is planning short-term courses outside the School curriculum at locations throughout northeast Ohio.

Paul B. Eib, D. D. S., deputy regional medical director in the Veterans Administration Central Office, Washington, D. C., has been named director of the Brecksville, Ohio, VA hospital. He succeeds James W. Standeven, M. D., who has been appointed director of the Montgomery, Ala., VA hospital.



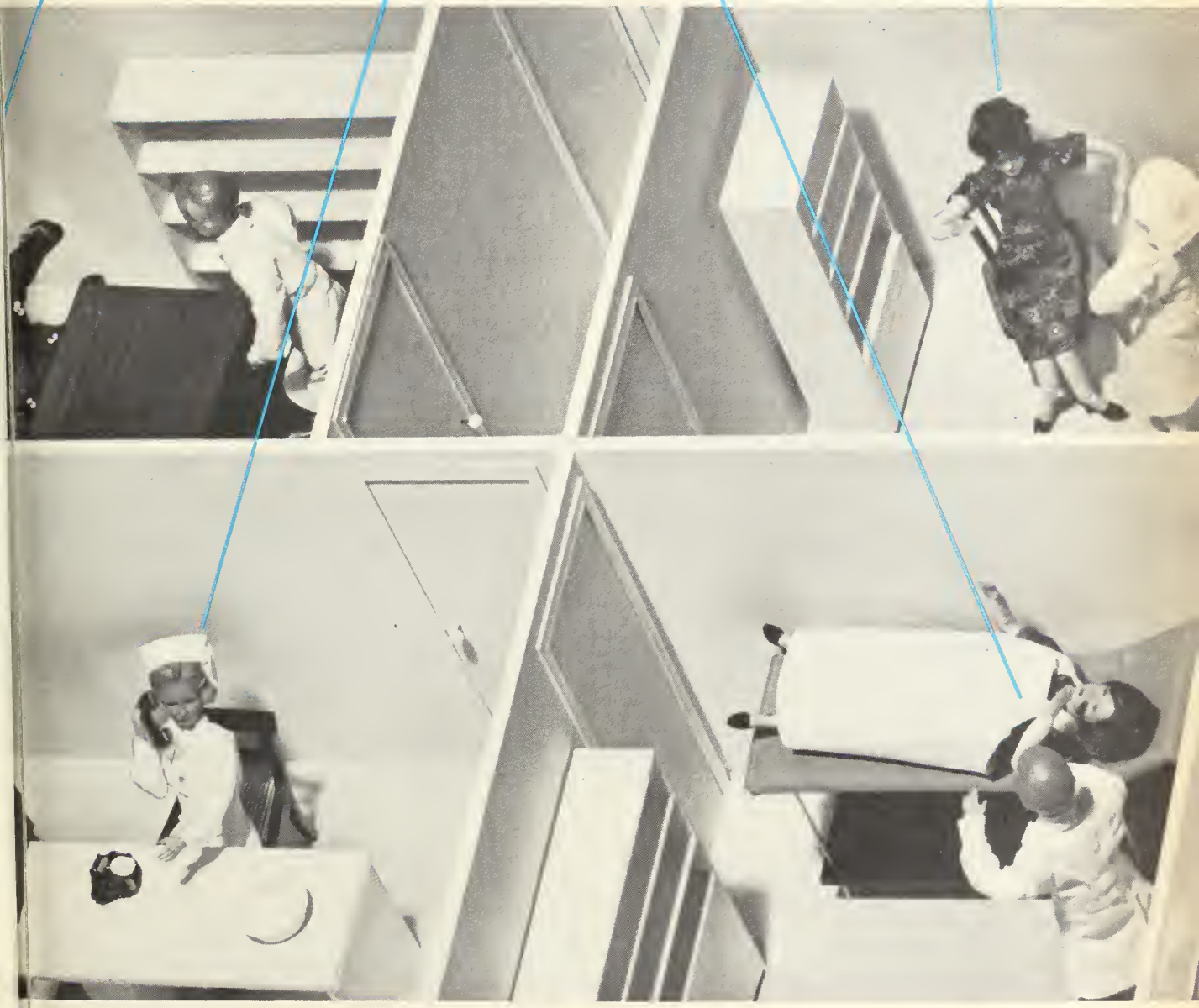
When the emotionally impaired patient pays an office call...

She asks for your help, but just can't seem to follow through on your advice.

When not at your office, she's constantly on the phone: can't sleep, headache, G.I. upset.

She often seeks a physical explanation for her distressing emotional state.

She's excessively apprehensive; demands much more of your nurse's attention.



...derate to severe anxiety...

...llaril helps control the most frequent symptoms: marked ...on, agitation, apprehension, restlessness, hypermotility ...llaril often alleviates anxiety-induced somatic complaints ...llaril frequently helps strengthen emotional resources ...llaril helps the patient maintain ...tic contact with environment, closer ...ony with family

...raindications: Severely depressed or ...tose states from any cause, and in ...iation with or following MAO inhibi... ...severe hypertensive or hypotensive ... disease.

...utions: Hypersensitivity reactions ... leukopenia, agranulocytosis) and ...lsive seizures are infrequent. Pig... ...ary retinopathy has been observed ... doses in excess of those recom... ...ed were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

for moderate to severe anxiety

Mellaril®

(thioridazine)

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68-115

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now . . . specific therapy for night leg cramps

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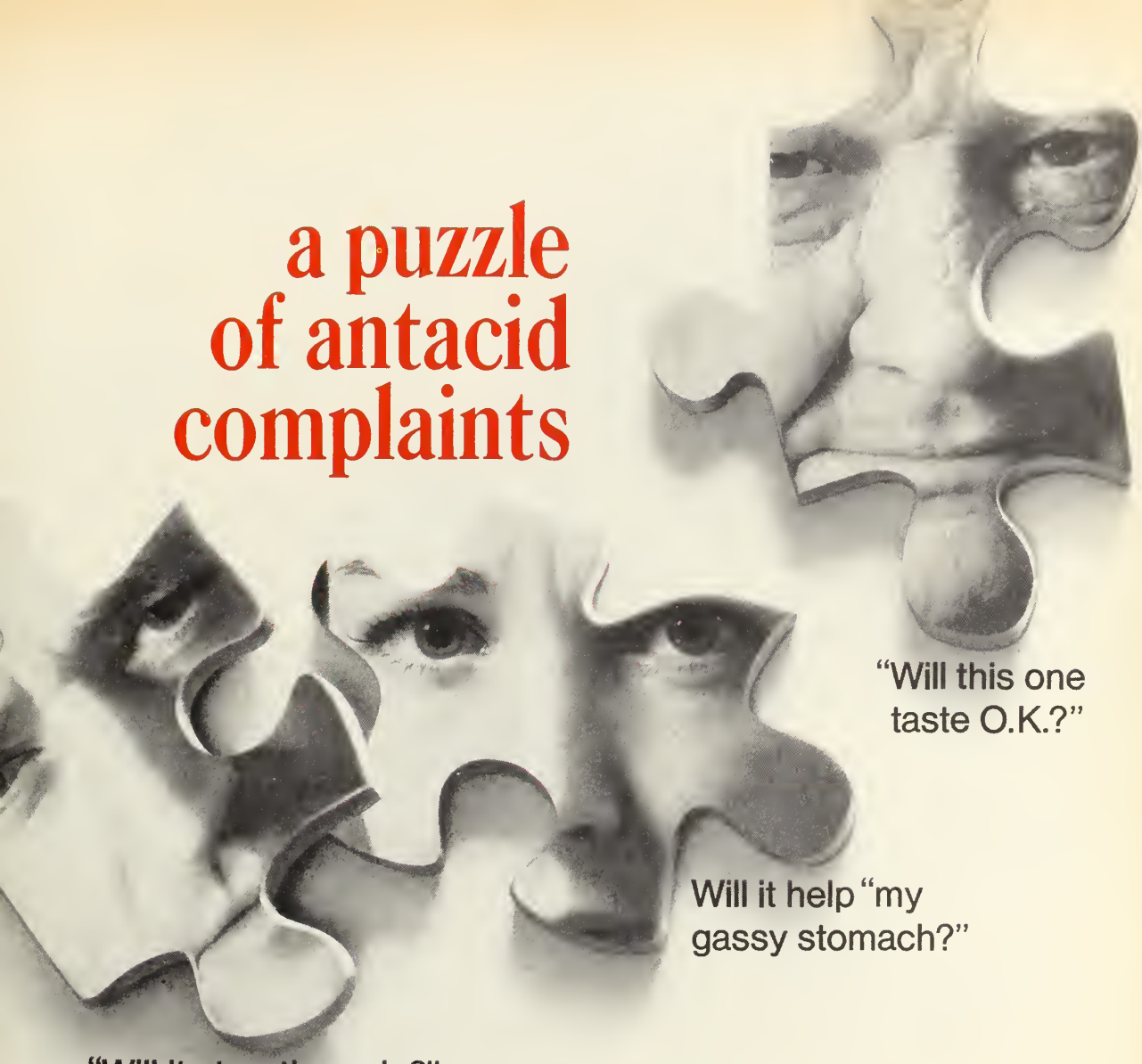
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Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A

a puzzle of antacid complaints



Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I.E., Personal communication.

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Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

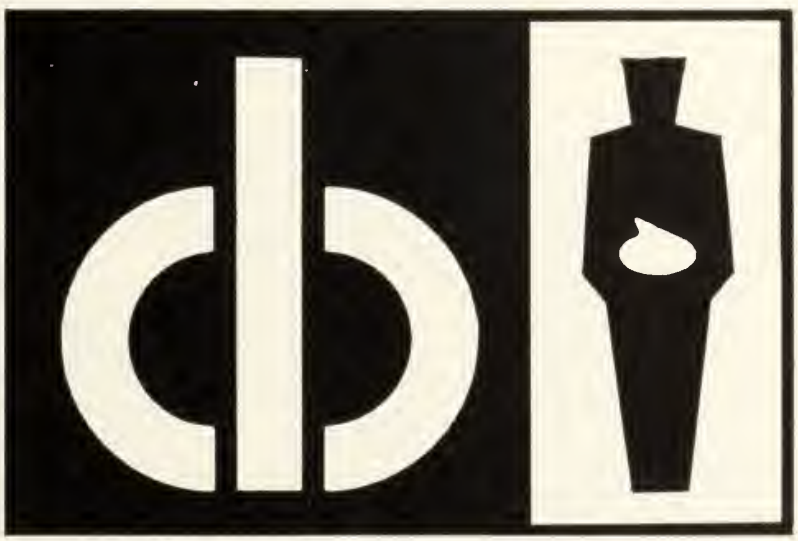
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OSMJ

Scientific Section

VOL. 64 APRIL, 1968 NO. 4

Variations in Human Bronchial Artery Anatomy

A Series and Clinical Significance in Current Carcinoma Therapy

RONALD J. FADEL, M.D., and GEORGE R. L. GAUGHRAN, Ph.D.

INTEREST in the origin and distribution of the bronchial arteries essentially parallels periodic discoveries about their clinical significance. Although the vessels were known to Galen and found to anastomose with the pulmonary system by Ruysch in 1721, their descriptions through the 1800's by various workers were inconsequential. Moreover, there is a paucity of discussion concerning their anatomy in most modern anatomy texts. What description does exist appears to have been uncritically copied from Haller's Icorium Anatomicarum (1747) into a long line of standard works as recently as 1942.

That these vessels merit detailed consideration is evidenced by a number of facts about their physiology. They have long been known to provide the nutrient supply to the lungs and to form anastomoses with the pulmonary system. Moreover, they undergo dilatation in acute and chronic inflammatory states, congenital cystic disease, infection and even partially compensate for pulmonary circuit failure. Indeed, Edwards and Eglitis[1] described a case of a 25 year old woman with congenital absence of the pulmonary arteries. The entire arterial supply in this woman's lungs was through markedly enlarged bronchial arteries.

Currently these vessels have gained increased attention by clinicians treating patients with pulmonary carcinoma. The unique feature of pulmonary neoplasms is that they uniformly take their vascular supply from the bronchial arterial system. This, then, allows for selective angiography as well as selective antimetabolite perfusion of lung tumor masses. Their dynamic nature and their role in malignancies and surgical procedures makes details of their origin and distribution currently important.

A review of the literature reveals a number of isolated studies on the origin and distribution of these vessels. Cauldwell *et al.*,[2] reviewed 150 cadavers and observed that the bronchial arteries with few exceptions took origin from the proximal part of the thoracic aorta arising independently, in multiples from a common stem or in company with a functionally unrelated vessel. He catalogued his specimens on the basis of types (I through X) according

The Authors

● Dr. Fadel, Lexington, Kentucky, is Intern-Straight Surgery, University of Kentucky Medical Center at Lexington.

● Dr. Gaughran, Columbus, is Professor and Vice Chairman, Department of Anatomy, The Ohio State University College of Medicine.

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to origin, course and distribution. Types I through III constituted over 80 per cent of his series and are indicated below:

Type I	2 left bronchial arteries 1 right bronchial artery	40.6%
Type II	1 left bronchial artery 1 right bronchial artery	21.3%
Type III	2 left bronchial arteries 2 right bronchial arteries	20.6%

Furthermore, he noted that the aortic sites of origin of the right bronchial arteries differed from those of the left side not only in position but in relation to parietal vessels. They arose on the right anterolateral, lateral, or posterolateral surface of the aorta. In 88.7 per cent of his cases the right bronchial arteries arose in common with an intercostal artery. Conversely, the left bronchial arteries most commonly arose from the anterior surface of the aorta or from the arch and seldom arose in common with an intercostal. In the exceptional cases, they took origin with a right rather than a left intercostal.

In all of Cauldwell's specimens, without exception, at least one left bronchial artery arose independently from the thoracic aorta. The range of origin level was from T-3 to T-8 with five-sixths of the vessels originating at the T-5 and T-6 level.

Marchand *et al*,[3] studied material in Johannesburg and found that there were usually two main arteries, one to each lung, which most commonly arose separately from the aorta. In addition, his cases revealed one or more smaller arteries arising directly from the aorta. Marchand places the origin of these latter vessels to be ½ inch distal to the main bronchial arteries but adds they may arise from any part of the aorta above the diaphragm. The commonest site of origin of the main bronchial arteries was from the anterolateral aspect of the aorta about ½ to 1 inch distal to the origin of the subclavian artery often in conjunction with an intercostal. Upon reaching the bronchi the vessels progressed distally along the posterior aspect. In those cases with more than one bronchial artery to a lung, the superior supplied the greater portion of the lung while the inferior seldom supplied more than the posterior and medial aspect of the lower lobe.

In a series of ten autopsy cases presented by Cudkowicz and Armstrong[4] an injection technic followed by roentgenographs was employed. Although these workers were concerned primarily with the intraparenchymal patterns of the bronchial arteries, they also documented the origins of the vessels. The ten preparations suggested that the bronchial arteries emerged in varying numbers, often two to each lung from the inferior aspect of the arch of the descending aorta, near the level of the fifth and sixth thoracic vertebrae. They further add that these findings are not constant and as many as three vessels were noted to enter the hilum on one or the other side. Origins from sources other than the aorta were not noted in his series. Although the intercostal arteries were divided about two inches away from their aortic origin, subsequent dissection and removal of the lungs revealed no evidence of systemic arteries to the lungs which might have arisen from the distal intercostal arteries.

Although the predominant situation is one in which the bronchial arteries take origin independently near the arch or in conjunction with a posterior intercostal, other less frequent origin sites have been described. Cauldwell[2] and Marchand[3], among others, denoted additional bronchial vessels traversing the pulmonary ligament. These vessels appear to be twigs from aortic esophageal arteries.[2] The lower the origin of these vessels from the aorta, the more limited is their distribution in the lungs. Though superficially they appear inconsequential, they can be the source of annoying and sometimes troublesome bleeding during pneumonectomy or lower lobectomy.[3]

Bronchial arteries have also been seen to arise from the subclavian, internal thoracic, superior intercostal and inferior thyroid arteries.[2,5,6] There is some question, however, as to whether these vessels are truly bronchial arteries or represent anomalous pulmonary arteries.[2]

Nothing specific is known about the embryology of the bronchial vessels, and the fragmentary discussions which can be found in the literature are purely speculative. Keibel and Mall[7] bluntly state "as far as I know, nothing has been ascertained concerning the development of the bronchial arteries." Walmsley[8] considers the bronchials to be continuations of splanchnic vessels to diverticula of the gut. He feels that the "usual origin" of the right bronchial vessel from the first aortic intercostal artery must result from enlargement of an anastomosis between a splanchnic vessel and the first part of an intersegmental somatic vessel.

It is the purpose of this paper to present in a series of 19 cases, the origin and distribution of these arteries, a comparison of this to other series, and a discussion as to the clinical significance of their anatomy particularly in relation to cancer chemotherapy.

Materials and Methods

This study is based on the survey of cadavers used for routine student instruction at the Ohio State University School of Medicine. All cadavers were examined in the course of thoracic dissections performed from the anterior approach. An anterior thoracic rib cage flap was reflected superiorly. The lungs were then removed taking care to sever the hilum just proximal to the first bronchial division. This was followed by removal of the heart by

transecting the major vessels at their bases. Only those specimens in which the regional mediastinal anatomy was unquestionably intact were used. Count was determined by examining the distal end of the transected bronchus. Vessels were then dissected, starting distally and progressing centrally to their origin.

Observations and Discussion

Table 1 shows a classification of cases according to the number of arteries to each lung. For purposes of discussion Cauldwell's classification, Types I through X, is used. In this series, the most common pattern observed was Type III, two bronchial arteries to each lung. This pattern type, as well as others observed, is recorded in Table 1 along with the number of cases and percentages. They are listed in descending order of frequency. The range

TABLE 1. *Pattern of Bronchial Arteries*

Cauldwell Type No.	Arterial Distribution Types	Cases	% of all cases
III	2 Right bronchials 2 Left bronchials	6	31.0
II	1 Right bronchial 1 Left bronchial	5	26.3
VI	3 Right bronchials 2 Left bronchials	3	15.7
I	1 Right bronchial 2 Left bronchials	2	10.5
IV	2 Right bronchials 1 Left bronchial	2	10.5
V	1 Right bronchial 3 Left bronchials	1	5.2

of origin level is between T-3 and T-7 with all but eight arteries arising in the T-4 to T-6 region.

Aortic sites or origin, as well as mode of origin, are highly variable. In those cases where a bronchial artery was found to arise from a posterior intercostal the common trunk was identified as an intercostobronchial trunk. This term is one adopted by Cauldwell and is also used in this series for clarity. A total of 17 bronchial arteries arose from right intercostobronchial trunks and all of these were to the right lung. Thus, 52 per cent of the right bronchial arteries in this series took origin from an intercostobronchial trunk. The intercostal spaces supplied by these trunks ranged from the second through the fifth with the majority[9] supplying the third intercostal space. Aortic origin sites included both lateral and anterior aspects and did not necessarily fall into series with the intercostal branches. The vessels themselves were found on all aspects of their respective bronchi without any consistency.

Of remarkable significance is the additional nonpulmonary nutrient supply which the bronchial arteries were observed to have. All cases showed branches to regional nodes, adjacent esophagus and pericardium. In addition, several cases revealed small branches traveling posteriorly into the spinal system. In one case, the third through fifth intercostal arteries gave large recurrent branches to the esophagus.

Figures 1 and 2 show schematic drawings of representative cases found for each type of distribution pattern. This is further augmented by a description of the manner of origin:

Type a: Two left arteries, one right artery (2 cases). Both cases are illustrated in Figure 1. In one case all three vessels originate from a common trunk whereas, in the second case all three vessels have independent origin from the aorta on the left and an intercostobronchial trunk on the right.

Type b: One left artery, one right artery (5 cases), Fig. 1. Three of these cases have common trunk origins directly from the aorta as illustrated. The remaining two cases reveal separate origins either from the aorta or from an intercostobronchial trunk.

Type c: Two left arteries, two right arteries (6 cases), Fig. 1. Of these six cases only two are similar and are schematically shown in the first drawing in Figure 1. Both cases have a common trunk arising from the aorta which in turn gives an arterial branch to each bronchus. The second right bronchial artery arises from an intercostal trunk while the second left bronchial vessel has an independent aortic origin. One case has a common trunk giving rise to one right and both left bronchial arteries with the second right vessel originating from an intercostobronchial trunk. Another case is nearly the exact opposite of the latter with a common trunk giving rise to both right and one left vessel, the second left artery arising independently from the aorta. The remaining two cases of this type are unique in that they reveal a bronchial arterial trunk arising from an intercostobronchial trunk. (See last 2 drawings, Fig. 1.) In the first of these, the bronchial trunk trifurcates providing one left and both right vessels with the remaining left artery taking origin directly from the aorta. In the second case, the bronchial trunk arising from the intercostobronchial vessel bifurcates into both right arteries. The left bronchial arteries arise from a trunk taking origin directly from the aorta.

Type d: One left artery, two right arteries (2 cases), Fig.2. Both of these cases were identical in the manner of vessel origin. The left and one of the right bronchial arteries arise from an aortic trunk with the remaining vessel arising from an intercostobronchial artery.

Type e: Three left arteries, one right artery (1 case), Fig. 2. As shown in the schematic drawing, this case has one vessel from an intercostobronchial artery and the remaining ones arising from two aortic trunks.

Type f: Two left arteries, three right arteries (3 cases), Fig. 2. All three cases are shown in this

figure. Whereas the first case is unremarkable, the last two demonstrate unique features. In the second, there is a large bronchial trunk arising from the aorta in much the same manner as an intercostobronchial. This common trunk gives rise to two of the right bronchial arteries before terminating in a series of large caliber pericardial branches. In the last case, all the right bronchial vessels arise from two intercostobronchial arteries.

Discussion and Clinical Aspects

The calculation of a chi square for this series compared to Cauldwell's series, although indicated, is impossible to perform since it is not known whether the samples compare favorably as to sex and race distribution. However, the present findings both differ from and confirm previous investigations.

Type III pattern constituted the highest incidence at 31.0 per cent. Cauldwell found this type to be the third highest in his series at 20.6 per cent.[2] In 52.0 per cent of the cases, a right bronchial artery arose from an intercostobronchial vessel, compared to the 88.7 per cent in Cauldwell's series.

Marchand, as previously cited, found single bronchial arteries to be the most predominant pattern. Cauldwell places this pattern at 21.3 per cent. In this series five cases were found for 26.3 per cent incidence. Although these figures compare favorably, the manner in which the vessels originate does not. Three of the five cases were common trunk origins while Cauldwell found only 4 out of 32 cases of Type II to arise in this manner. Indeed, the overall incidence of common trunk origins excluding intercostobronchial vessels varies considerably between series. Recently in 100 radiologic examinations, Viamonte[6] found 32 cases. Cauldwell found 39 in 150 cases while the present series had an incidence of 16/19.

Although the arch of the aorta was found to be involved as a site of bronchial arterial origin, none of the less common sites of origin, such as the subclavian, carotids, etc., was seen in this investigation. However, the vertebral levels of origin compare well with the observations of other workers[2,4] both in range and average. (See also Table 2.)

Aside from intercostal arterial relationship, the bronchial arteries are involved in a number of regional vascular anastomoses. In a considerable number of cases, extensive significant anastomatic as well as direct vascular relationships occur between the bronchial arteries and the esophagus.[2,4,10] The pre-

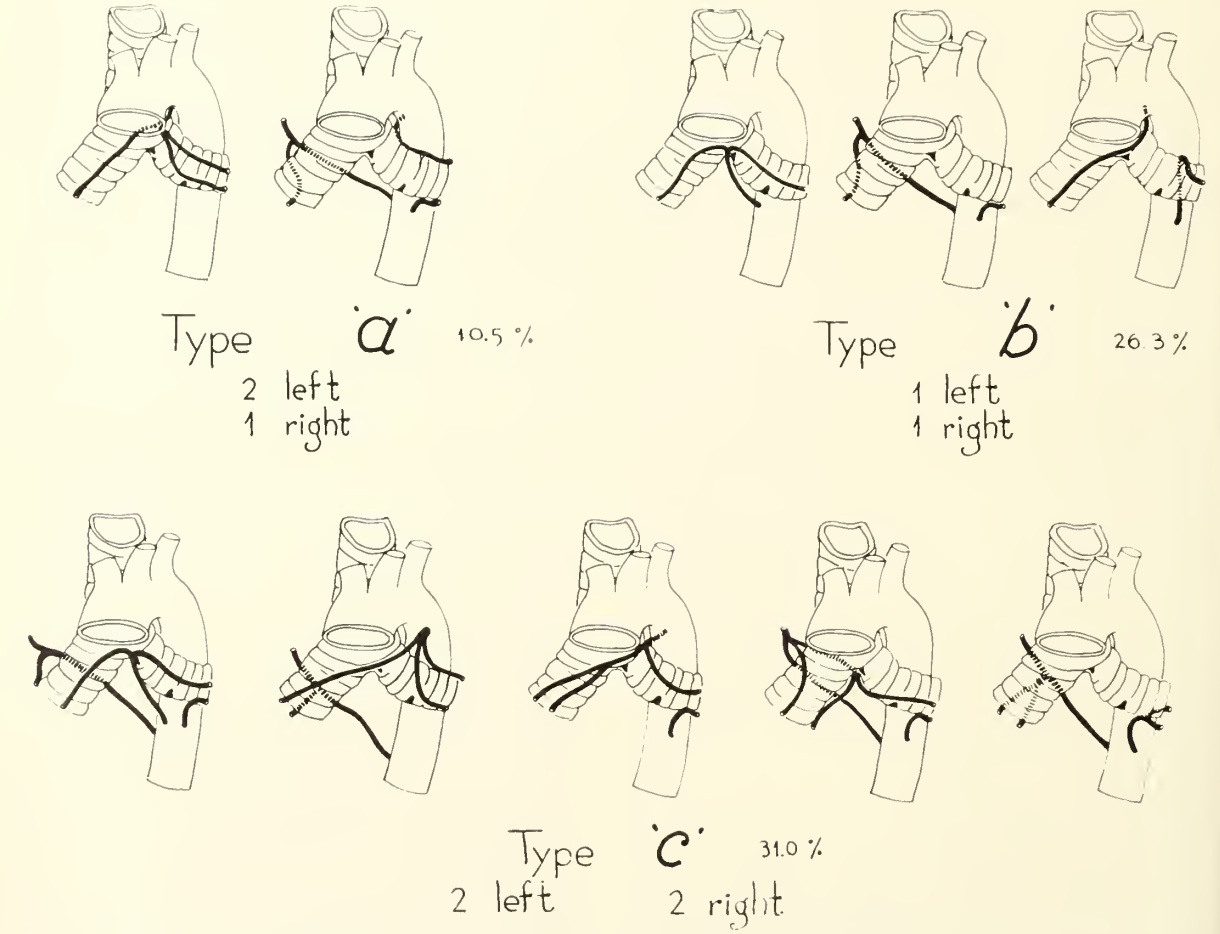


FIG. 1. *Representative cases of various types of bronchial arteries.*

dominant blood supply of the middle third of the esophagus is considered to be the bronchial arteries, with contributions to the cervical portion as well.[2, 11] In addition, the paratracheal and bronchial lymph nodes receive an abundant blood supply from the bronchial arteries. These esophageal and lymphatic relationships were consistently confirmed in the course of the dissections presented here. One case showed esophageal branches arising from the intercostal arteries in a manner similar to intercostobronchial vessels.

Although the esophagus and regional nodes constitute the major vascular relationships with the bronchial arterial system, other minor relationships exist. According to Cauldwell, Hudson demonstrated widespread anastomoses of bronchial arteries with auricular branches and coronary branches to the pericardial fat. Anastomoses between bronchial arteries and the right subclavian and superior intercostals by way of the vessels supplying the paratracheal and proximal bronchial lymph nodes also have been described.[2] The pericardial branches seen by other workers were also noted in the cases presented here.

Further vascular relationships involve the central nervous system. According to Elliot,[12] the anterior and posterior spinal arteries receive radicular branches from the intercostals. In the thoracic region, the longitudinal vessels may be attenuated, even discontinuous. Of the more than 30 radicular twigs, only two to four of them actually connect to each longitudinal spinal artery in this region. One case in this series provides evidence that these radicular twigs do not necessarily arise exclusively from intercostals. A large caliber vessel was found to arise from a bronchial arterial trunk passing superiorly and retrograde into the cord.

Mention has already been made concerning the bronchial arterial anatomy as it relates to various pathologic states. They offer little problem to the surgeon, but their current role in selective chemotherapy merits consideration of the potential hazards.

The prevalent technic employs fluoroscopy to obtain catheterization of the bronchial arteries via a percutaneous, retrograde femoral arterial approach. The purpose is to deliver a considerably higher dose of

TABLE 2. *Vertebral Level of Bronchial Artery Origin*

Vertebral Origin Level	Total Bronchial &/or Intercostobronchial Arteries	
	Right	Left
T-3	2	2
T-4	9	10
T-5	9	9
T-6	11	9
T-7	2	2
Total number of arteries	33	32

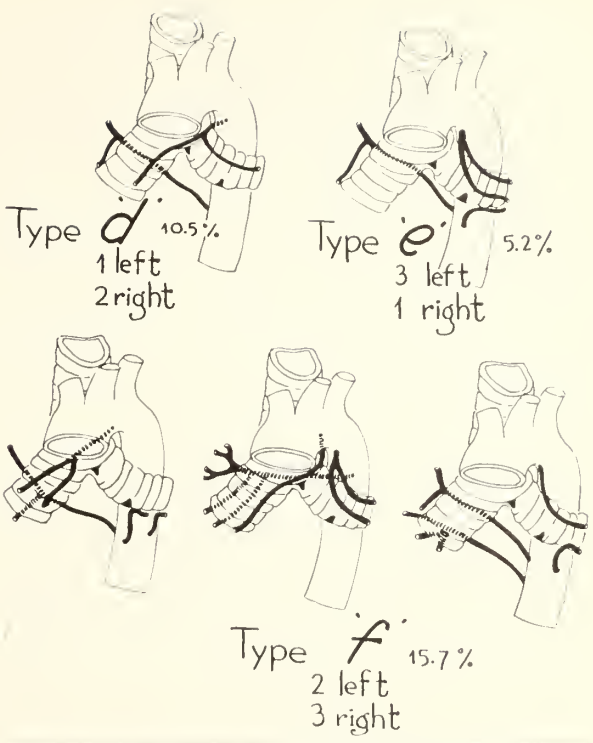


FIG. 2. *Representative cases of various types of bronchial arteries.*

antimetabolite to the malignant tumor than could be achieved by parenteral administration of the drug, thus avoiding the systemic, toxic side effects. Initial studies indicated, however, that toxic side effects, nevertheless, do occur.

Reuter[9] noted that injections of intercostobronchial trunks are quite painful because of the neurovascular relationships previously mentioned. Rheinlander,[13] working with 35 dogs, reported nine cases in which the bronchial arteries arose as branches of an intercostobronchial trunk. Following injections with nitrogen mustard, marked general reactions occurred, with shock, anorexia, weight loss, leukopenia, and two cases of paraplegia. Bronchial artery anastomoses and nonpulmonary vascular contributions readily explain these examples of systemic spill over and neurologic complications. The unique vascular anatomy of the thoracic spinal cord renders the lower cervical and upper thoracic segments to T-4 particularly susceptible to nervous tissue death if the blood supply is interrupted. Animal studies on the effect of temporary vascular occlusion showed that motor power did not reappear in animals after 20 minutes.[14] However, actual clinical experience indicates that vascular occlusion alone does not in itself necessarily lead to nervous tissue damage. Fergelson[15] feels these observations suggest that there must be specific tissue injury secondary to idiosyncrasy or allergy to the contrast media in addition to or in place of vasospasm to account for the development of transverse myelitis. Should this be the case, localization

of the bronchial vessels with contrast medium followed by massive injections of antimetabolite further increases the neurological hazard.

Viamonte,[6] in his series, employed a blind end catheter with an opening along the side for selective perfusion of the bronchial arteries which arose from intercostal trunks. Such a device certainly prevents spill over of contrast media and follow-up antimetabolite into the distal intercostal. However, total occlusion time remains important. Moreover, in those individuals with spinal branches stemming directly from the bronchial arteries rather than from an intercostobronchial trunk, the blind end catheter could not prevent spinal cord contamination.

The potential hazard is not confined to neurotoxicity. The extensive bronchial-esophageal arterial anastomoses noted here and by other investigators renders the esophagus an organ for serious concern during therapy. Esophagitis with mucosal slough secondary to antimetabolite assault is a questionable price to pay for tumor palliation.

Summary

Nineteen cases of bronchial artery origin and distribution are described and compared to other series. The results of this investigation and other series indicates that the question of bronchial artery origin is unsettled. The origin very well may vary with the size, sex, and race incidence of the sample.

Regional bronchial artery anastomoses involves the posterior intercostal, esophageal, and spinal arterial system. These relationships are significant in providing avenues to neurotoxicity, esophageal necrosis, and generalized systemic toxicity, when selective pulmonary tumor perfusion is undertaken.

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A SYMPOSIUM ON RENIN MECHANISMS AND HYPERTENSION, which represents the culmination of 40 years of work, has been reprinted by the American Heart Association.

The symposium consists of the 1966 two day scientific sessions of the Association's Council for High Blood Pressure Research. The proceedings demonstrate the wide range of disciplines involved in studying the hypertension problem and lends support to the theory that no single cause may be blamed for the condition.

The 19 articles which comprise the symposium were edited by J. Edwin Wood, M. D., with an introduction by Sir George Pickering and concluding remarks by Irvine H. Page, M.D., Director-Emeritus of Research at the Cleveland Clinic. Published as Volume 15 in AHA's Hypertension Series, the symposium may be obtained through local Heart Associations. — Ohio State Heart Association, 10 East Town Street, Columbus, Ohio 43215.

Pulmonary Agenesis and Hypoplasia

A Case Report

ROBERT M. STANKEY, M.D.

THIS ARTICLE is written with a twofold purpose: to review the findings of pulmonary agenesis and hypoplasia and to present an illustrative case. For many years this entity has been held to be a rare congenital abnormality. Nevertheless, there are approximately 160 cases reported in the literature.[1] The words *agenesis* and *aplasia* have been used interchangeably to denote absence of the lung. The term *agenesis* is somewhat more restrictive and is preferable.

Case Report

The patient is a 20 year old white man, who is a twin. According to parental history, he was born after a 28 to 30 weeks' gestation. Until the present time, he has played varsity football at college and has been in good health. This young man has noted that it required a longer time for him than for his twin brother to attain the desired level of physical fitness.



FIG. 1. *Opaque left chest, shift of heart, mediastinum, and trachea to left.*

A chest roentgenogram obtained as part of an armed forces physical examination revealed an abnormality of the left lung. He was sent to our office for additional chest roentgenograms, which showed that the left hemithorax was nearly homogeneously dense, with marked shift of the trachea, mediastinum, and heart to the left. The right lung was overexpanded and had herniated across the midline. The intercostal spaces on the left were narrowed (Fig. 1). It was thought that there might be an atelectasis of the left lung, but, considering the lack of symptoms, a tentative diagnosis of pulmonary agenesis was also offered.

He was admitted to Toledo Hospital, and laboratory studies disclosed the hemoglobin to be 15.8 gm./100 cc., while the other laboratory tests also demonstrated results within normal limits. The electrocardiogram revealed a pattern of right ventricular hypertrophy, which may be only a reflection of the known cardiac displacement and rotation. The heart rate was 50 beats per minute. Pulmonary function tests were within normal limits but did disclose the total vital capacity to be 83 per cent of the predicted value and suggested the presence of a mild restrictive ventilatory insufficiency.

Physical findings were chiefly those of diminished breath sounds on auscultation of the left chest. The chest did not appear to be asymmetrical, however, the patient is quite muscular. He weighed 180 lbs.

The Author

● Dr. Stankey, Toledo, is Associate Radiologist, and a member of the Active Staff, St. Vincent Hospital and Medical Center.

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(81.8 kg.) and was 5 ft. 11½ inches (181.6 cm.) tall. All peripheral pulses were strong and equal. No heart murmurs were found.

Bronchographic studies were done and disclosed a small left main stem bronchus with a very small amount of attached lung tissue. This hypoplastic bit of tissue contained rudimentary bronchi. The right bronchial tree was rotated and the right lung was emphysematous but was otherwise of normal appearance (Figs. 2 and 3). Pulmonary arteriography was suggested but was refused.

Discussion

A morphological classification of these pulmonary defects, which has proven useful over many years, is that of Schneider. As cited by Ferguson and Neuhauser,[2] three classes form depending upon the time at which they occur during fetal development. Class 1 represents true agenesis, with no lung, bronchus, or vascular supply. In class 2, there is a rudimentary bronchus, but no lung tissue is present. In class 3, a small, but formed bronchus exists in connection with varying amounts of pulmonary alveolar tissue. The case presented here falls within Class 3.

Pulmonary agenesis and hypoplasia are found within a very wide range of ages. Unilateral agenesis is not incompatible with long life. The presence of various concomitant anomalies is high; some of these are minor, some are major. Of the associated anomalies about 25 per cent are of a vascular nature, patent ductus arteriosus being the single entity most often found.[3] The coexistence of major congenital defects often determines the prognosis. The effects of chest trauma or respiratory infections are obviously of considerable import.

There is no particular sex difference nor is there a predominantly affected side,[4] but a difference in survival rates between the two sides does exist. Agenesis of the right side is more ominous than that of the left.[5] Smith and Bech[6] suggest this is because there are fewer associated major defects when the left side is involved. Symptoms are of variable degree and, in uncomplicated agenesis, are often absent. When present, they may be the symptoms of an associated congenital defect.

The examining physician usually finds some flattening of the affected side, but ordinarily no pronounced thoracic asymmetry. The heart is displaced toward the affected side, but if displaced to the right, it should not be mistaken for simple dextrocardia. Diminished breath sounds and dulness to percussion may also be present on the involved side.

The conventional chest roetgenogram displays features as described in the case presented, with the midline structures moving toward whichever side is involved. Bronchoscopy will show an absent or rudimentary main stem bronchus. Bronchography is very useful to outline the bronchial extent of the defect. Angiocardiography, the most definitive study, will prove the diagnosis and show absence of the pul-



FIG. 2. *Compensatory emphysema and herniation of right lung across midline with rotation of bronchi. Tiny and hypoplastic left lung.*



FIG. 3. *Detail of left lung. Note relative size and angulation of main stem bronchi.*

monary and bronchial arteries besides demonstrating the amount of cardiac rotation which has occurred. This study will also reveal associated vascular anomalies as well as possible compression of major vessels.[1,2]

Summary

A case of extreme hypoplasia of the left lung in an asymptomatic, vigorous, 20 year old man has been presented. This condition is found within a very wide range of ages, without significant sex differentiation or predilection for a particular side of the chest. It may well be asymptomatic. Symptoms, if present, are often those of an associated congenital defect, since these defects frequently coexist. Diagnosis by physical examination and conventional roentgenograms is presumptive, bronchoscopy and bronchography are more informative, while angiocardiography offers definitive diagnosis, besides revealing the presence of complicating vascular anomalies.

Acknowledgment: The author wishes to thank Dr. W. Taylor, Jr., and Dr. J. Roshe for permission to review the records of their patient as well as Dr. W. Peck, Chairman, Department of Radiology, Toledo Hospital, for permitting reproduction of their bronchographic studies.

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RESULTS OF PSYCHOTHERAPY — A controlled double blind study was made of 299 non-psychotic female psychiatric clinic patients divided into six groups, with members of each group dealt with in a different manner from those in other groups. Those in one group had one or two hour-long psychotherapy sessions a week. Four groups were limited to brief visits but were given one of three kinds of drugs or a placebo. One group was merely put on a waiting list and received no therapy. As determined by a variety of independent measures, there was a fairly uniform average improvement of all groups except the one that received no treatment. Follow-up 10 to 18 months after termination of treatment revealed that the average patient had maintained her improvement and that those who had received no treatment showed considerable improvement after they were removed from the waiting list.

The findings suggested that the widespread preference for the traditional outpatient psychotherapy is based as much on the physician's bias as on proven greater effectiveness over briefer treatment methods. There was some confirmation that many things other than the development of understanding enter into much of the so-called psychoanalytically oriented psychotherapy and may have profound effect on the outcome. — Norman Q. Brill, M.D., Los Angeles: *California Medicine*, 104:249-253, April 1966.

Clinical Uses of Human Growth Hormone

MANUEL TZAGOURNIS, M.D., and THOMAS G. SKILLMAN, M.D.

A GREAT DEAL of information concerning human growth hormone (HGH) has accumulated during the past few years. The significant advances which led to the isolation and purification of HGH have enabled workers to study its specific effects on aspects of metabolism other than the well-known growth-promoting properties.[1-3]

Growth hormones from different species vary considerably in structure, molecular weight, immunological properties and physiochemical characteristics. HGH is a single unbranded polypeptide with a molecular weight of approximately 21,000. Since the molecule is highly species-specific, successful treatment of human subjects can be achieved only by utilization of extracts derived from human pituitary glands. In hypopituitary subjects, the administration of HGH prior to complete epiphyseal closure has resulted in satisfactory linear growth. The scant availability of human growth hormone, however, has limited its extensive clinical use.

Growth hormone is a potent anabolic substance and causes nitrogen retention and increased protein synthesis.[4] It increases the uptake of amino acids by cells, thereby providing building units for protein synthesis. It favors the formation of lean body growth in contrast to another anabolic hormone insulin, which increases body fat as well as protein.

The anabolic effects of growth hormone are not universal for all tissues. Protein anabolism is made possible to a large extent by energy provided from adipose tissue. Growth hormone stimulates lipolysis of depot fat with release of free fatty acids to the circulating plasma. The metabolic energy obtained from oxidation of free fatty acids spares amino acids in certain situations. The ability of growth hormone to mobilize fatty acids early in the course of fasting and during muscular exercise is particularly important.

The increased prevalence of diabetes mellitus in acromegalic subjects implies an important relationship between growth hormone and carbohydrate metabolism. The administration of growth hormone decreases glucose tolerance in normal subjects as well as in diabetic patients. This action of HGH appears to be, in part, related to growth hormone induced mobilization of free fatty acids. However, decreased glucose tolerance persists even when release of fatty acids is blocked by pharmacologic agents.[5] Although it appears that growth hormone and insulin have opposing influences on intermediary metabolism, the sequential secretion of the two hormones provides a synergistic balance. This relationship is best described by comparing "feasting" and "fasting." During food intake, insulin is predominantly secreted and facilitates carbohydrate utilization and fat storage. During fasting, growth hormone is secreted, and the stored fat is mobilized, while protein and carbohydrate are generally conserved. Accordingly, both hormones act to conserve the body's critical protein mass whether food is available or not.

The objectives of this paper are to review some of the physiologic factors which control growth hormone secretion and to demonstrate how they may be employed to evaluate clinical disorders of anterior pituitary dysfunction.

The Authors

● **Dr. Tzagournis, Columbus, is Instructor of Medicine, Division of Endocrinology and Metabolism, The Ohio State University College of Medicine.**

● **Dr. Skillman, Columbus, is Professor of Medicine and Director of the Division of Endocrinology and Metabolism, The Ohio State University College of Medicine.**

Measurement of Human Growth Hormone

The concentration of HGH in human plasma or serum is minute; the usual normal value is less than 10 millimicrograms (mμg) per milliliter. Attempts to measure such a low concentration by bio-assay methods have given conflicting results. Recently, a radio-immunoassay technique, using the principles originally reported by Berson and Yalow,[6] has been employed successfully to determine growth hormone concentrations.[7]

The sensitivity and specificity of the immunoassay is sufficient to permit measurement of the small fluctuations in growth hormone concentration which result from responses to various stimuli. The method used in our laboratory is based on a modification of the salt precipitation immunoassay described by

From the Division of Endocrinology and Metabolism, Department of Medicine, The Ohio State University College of Medicine, Columbus, Ohio. Submitted November 21, 1967.

TABLE 1.

PRINCIPLES OF RADIOIMMUNOASSAY REACTIONS

$$HGH^{-131} \underset{(FREE)}{} + \text{ANTIBODY} \rightleftharpoons HGH^{-131} - \text{ANTIBODY COMPLEX}_{(BOUND)}$$

$$+$$

$$\text{unlabeled HGH}$$

$$\Downarrow\Uparrow$$

$$\text{unlabeled HGH} - \text{ANTIBODY COMPLEX}$$

Grodsky and Forsham.[8] The principles are depicted in Table 1. Purified human growth hormone contains several tyrosine moieties which can accept a radioactive iodine molecule when properly oxidized. The labelling of the growth hormone molecule with radioactivity facilitates its measurement. Specific antibodies to human growth hormone are obtained by injecting a guinea pig with purified HGH. An extremely potent and specific antibody is necessary to assure an accurate assay. The labelled human growth hormone reacts with the specific antibody to form a labelled hormone-antibody complex. Increasing amounts of unlabelled growth hormone are added to the system. Competition between the labelled and unlabelled growth hormone for antibody occurs so that progressively less labelled (radioactive growth hormone-antibody) complex is found. Separation of the free radioactive growth hormone from the heavier labelled growth hormone-antibody complex is achieved by precipitation with 20 per cent sodium sulfate solution. An unknown concentration in serum can be calculated from a graphed plot upon which known amounts of growth hormone have been entered.

Control of Human Growth Hormone Secretion

The secretion of HGH, like other pituitary hormones, is regulated by the hypothalamus. Certain neurosecretory cells of the hypothalamus respond to a variety of stimuli and secrete a substance known as somatotrophin releasing factor (SRF). SRF is carried by a venous portal system from the hypothalamus to the anterior pituitary gland where it in turn stimulates the synthesis and release of HGH into the general circulation.[9]

Basal Levels of HGH. In normal subjects after an overnight fast, resting serum HGH values range from undetectable levels to 15 mμg./ml. Figure 1 displays basal HGH levels found in 40 normal subjects and compares them with the basal values found in 13 patients with acromegaly. Hypopituitarism results in low levels of HGH. However, because these levels overlap with the normal range, measurement of basal levels alone is insufficient for the diagnosis of hypopituitarism.

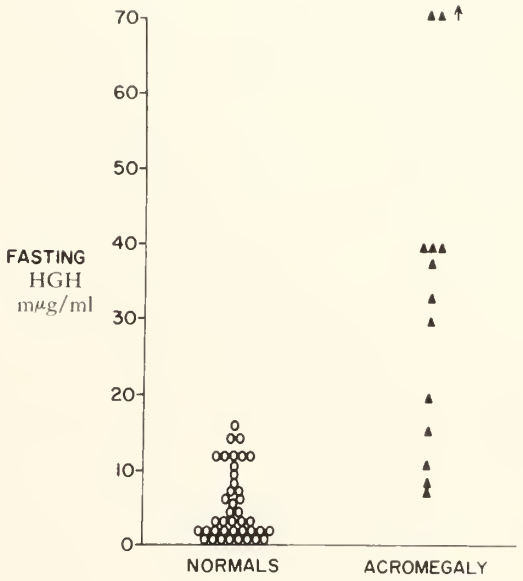


FIG. 1. *Basal serum HGH levels in 40 normal subjects and 13 patients with acromegaly after an overnight fast.*

HGH Response to Hypoglycemia. Many of the normal stimuli for HGH secretion are closely related to the body's defense against hypoglycemia.[10] Accordingly, the fall in blood sugar induced by intravenous insulin administration has been employed to test the capacity of the pituitary for HGH secretion. Crystalline insulin in a dose of 0.1 units per kg. body weight is infused suddenly after an overnight fast, and blood is obtained for determination of HGH before and at 20, 40 and 60 minutes after insulin.

The ability to increase HGH concentration in response to hypoglycemia separates normal subjects from patients with hypopituitarism (Fig. 2).

In contrast to normals, patients with acromegaly show little or no rise in HGH during insulin hypoglycemia. Their failure to respond probably reflects

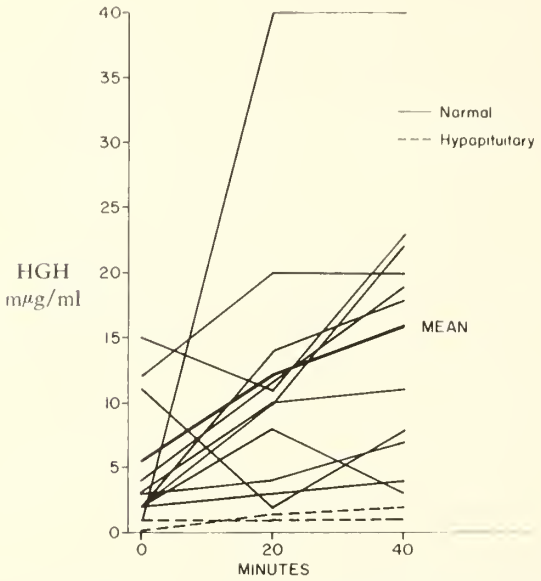


Fig. 2. *Comparison of the response of HGH to insulin-induced hypoglycemia in 11 normal subjects and 2 patients with hypopituitarism.*

an automatous state of growth hormone secretion by a pituitary adenoma.

Hypoglycemia itself is not always necessary for induction of glucose dependent HGH secretion. A rise in HGH can be seen after a rapid fall in blood glucose although hypoglycemic levels are not reached. Also, HGH levels increase during the slow reduction of glucose levels which are attendent to fasting and when intracellular utilization of glucose is inhibited by 2-deoxy-glucose.[11] HGH secretion in response to hypoglycemia may be inhibited by adrenal corticosteroids.[12] This effect could partially explain growth failure in children with Cushing's syndrome.

The insulin tolerance test may occasionally produce severe hypoglycemia in the hypopituitary patient. For this reason, other methods to evaluate HGH responsiveness have been devised.

HGH Response to Arginine Infusion. Although a number of amino acids stimulate HGH secretion, arginine has been found to elicit the greatest response.[15] An "arginine infusion test" is carried out by administering 0.5 gm. per kg. body weight of arginine monochloride in an isotonic solution intravenously over a 30 minute period. The maximum dose of arginine is 30 grams. Plasma for HGH is obtained before and at 30, 60, 90 and 120 minutes after beginning the infusion. Figure 3 depicts increments in HGH concentration induced by arginine. This provocative test has emerged as the most

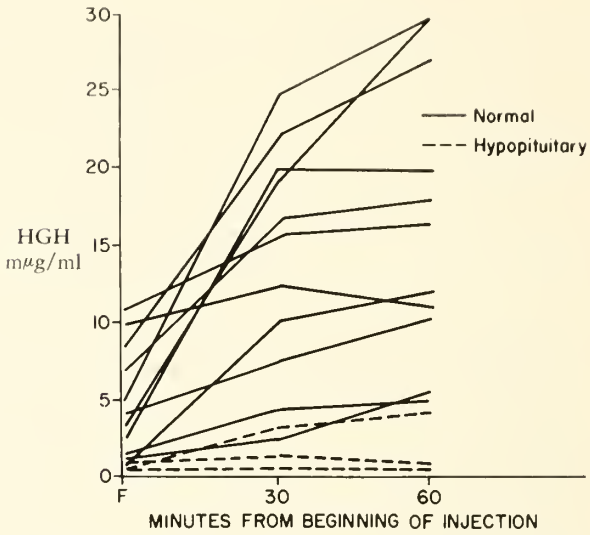


Fig. 3. *Comparison of the response of HGH to an infusion of arginine in 11 normal subjects and 3 patients with hypopituitarism.*

reliable and innocuous method of testing the capacity of the pituitary to secrete HGH.[16]

A major metabolic action of growth hormone is facilitation of amino acid uptake by peripheral cells. Amino acids bear a relationship to growth hormone as glucose does to insulin. Glucose stimulates the secretion of insulin which, in turn, facilitates cellular uptake of glucose. Similarly, amino acids stimulate

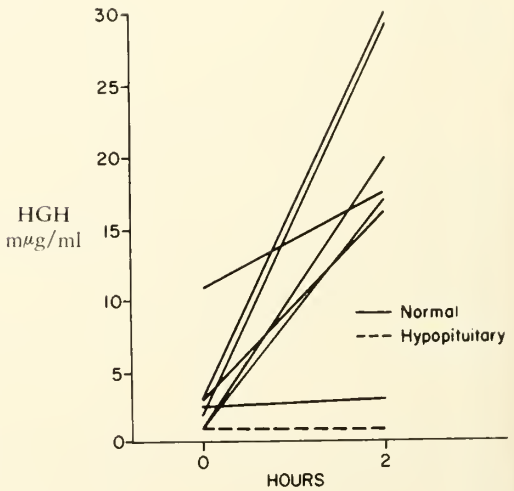


Fig. 4. *The response of HGH to an intravenous Pyromen® injection in 7 normal subjects and 1 patient with hypopituitarism.*

growth hormone secretion and growth hormone facilitates cellular uptake of amino acids.

HGH Response to Stress – The Piromen® Test. Stressful events such as febrile reactions, "fight or flight" situations, and surgery provoke the release of many hormones. Stress induced catecholamine secretion and corticotrophin secretion with attendent adrenocortical hormone release are well known. HGH secretion is also stimulated by stress. An example is given in Figure 4 where the HGH response to the infusion of Piromen®, a nonspecific thermogenic agent, is depicted. As with insulin hypoglycemia and arginine infusion, a "Piromen® test" may be used to evaluate pituitary HGH releasing capacity. Here 0.05 $\mu\mu$g/kg. of body weight as Piromen® is given intravenously, and serial HGH levels are measured. Interestingly, the rise in HGH induced by stress seems to be independent of glucose concentration and is not inhibited by glucose infusion.

Muscular Exercise. Since muscular exercise requires metabolic substrate for oxidation, and since growth hormone functions to conserve protein and carbohydrate at the expense of fat, it might be predicted that exercise would stimulate HGH secretion. The effect of muscular exercise on HGH as measured in our laboratory is shown in Figure 5. A greater magnitude of response is seen in women as compared

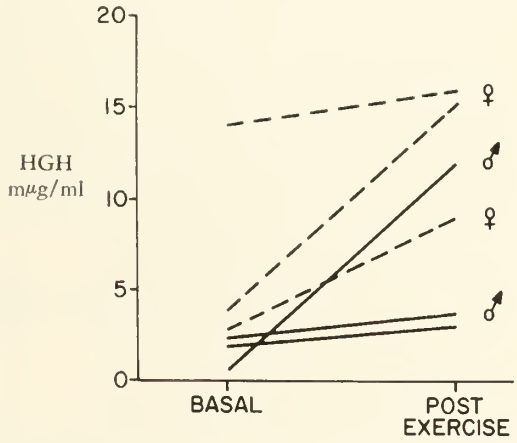


FIG. 5. *The response of HGH to exercise.*

to men. However, if men are pretreated with estrogen, their levels resemble those of women.[14]

Other Factors. The administration of vasopressin is associated with elevation of HGH levels. Because this substance has its origin in the hypothalamus and since the chemical composition of the somatotrophin releasing factor is unknown, it has been speculated that vasopressin may be similar to SRF. It appears more likely that vasoconstriction and other stresses induced by vasopressin cause HGH release through the nonspecific stress pathway rather than by specific pituitary stimulation.

Diurnal variations of HGH levels have been reported.[17] However, the fluctuations of HGH appear to be better related to changes in blood glucose levels associated with eating and fasting than to a basic independent rhythm. Children have wider fluctuations throughout the day than adults. Both premature and full term infants have high levels of HGH during the first 48 hours of life. The concentration slowly declines but remains higher at 8 weeks of life than in adults.[18] Obesity is associated with a relatively poor response of HGH secretion to the stimuli of hypoglycemia and fasting. A deficiency of thyroid hormone or estrogen and surfeit of corticosteroid hormones may reduce the response of HGH to normal stimuli.

During the latter stages of pregnancy, the placenta secretes a protein hormone, placental lactogen, which is metabolically and immunologically similar to growth hormone. This substance is believed to exercise growth-hormone-like effects.

Findings in Acromegaly

Diagnosis. The diagnosis of acromegaly can now be made quite accurately using the HGH immunoassay. The basal HGH values of acromegalic patients are usually higher than normal subjects but there is some overlap of values (Fig. 1). Accordingly, basal levels are not always diagnostic. When normal HGH values are found in a patient with clinical features of acromegaly, an evaluation to demonstrate suspected autonomous pituitary HGH secretion must be made. A normally responsive hypothalamic-pituitary system senses a decrease in blood sugar and responds with HGH secretion. Similarly, it can respond to an increased blood sugar by decreasing secretion of growth hormone. These responses are not seen when a growth hormone secreting pituitary tumor is present. In this situation, the administration of a glucose load fails to suppress plasma HGH concentration and permits the diagnosis of acromegaly. The test is carried out by measuring HGH in the fasting state and comparing the value to that obtained one hour after the oral administration of 100 grams of glucose. A comparison of HGH response to glucose loading in normal and acromegalic subjects is given in Figure 6. Normal subjects with mild elevations of HGH usually show a decrease to barely detectable levels, whereas, patients with acromegaly show little or no decrease.

HGH Immunoassay in Management of Acromegaly. In the past, it has been difficult to make a precise evaluation of the effect of surgery or radiation therapy in HGH secretion by a pituitary tumor. The indirect indices of HGH activity, such as decrease in serum inorganic phosphorous or improvement in glucose or insulin tolerance test, lack precision. The

ability to measure accurately HGH concentration before and after therapy introduces an exacting assessment of response.

Experience has now demonstrated that both conventional x-radiation and gamma radiation using a Cobalt [60] source are frequently insufficient to decrease the elevated HGH levels of acromegaly to normal.[19] Similarly, comparisons of HGH levels before and

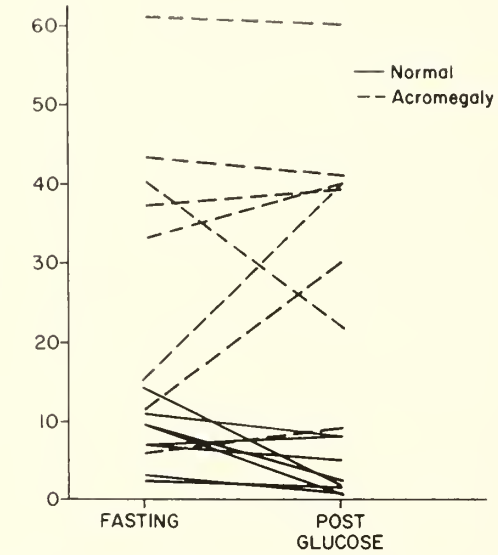


FIG. 6. *Comparison of the inhibition of HGH secretion by oral glucose intake in 8 normal subjects and 8 acromegalic patients.*

after the conventional subtotal surgical hypophysectomy often show an HGH decrease which is inadequate. Examples of this type of suboptimal responses are given in Table 2. This revelation has stimulated the development of methods of pituitary ablation, holding the promise of more effective destruction of the pituitary cells which elaborate growth hormone. A method which appears to offer much promise is heavy particle irradiation. This technic is based on directing a beam of radioactivity, derived by a cyclotron, directly at the pituitary tumor.[20]

Stereotactic positioning of the patient's head and consideration of the physical properties of the radiation source are employed, so that there is minimal radiation scatter to neighboring tissues and maximum energy is given to the pituitary. The early results of this method suggest that HGH values can usually be reduced to normal levels.[21] Wider experience with this method will be needed before it can be generally recommended. The same comments apply to the newer surgical approaches to pituitary tumor, total surgical hypophysectomy, cryohyphysectomy,[22] Gold[198] (Ref. 23) and Yttrium[90] (Ref. 24).

TABLE 2. *HGH Levels Before and After Co^{60} Irradiation or Subtotal Hypophysectomy (Normal < 15mμg./ml.).*

	mμgHGH Before	mμgHGH After
Co^{60} Irradiation	17	40
	13	30, 7
	40	51
Subtotal Hypophysectomy	80	69, 40
	40	40

Summary

Human growth hormone has many metabolic effects besides its growth-promoting properties. The response of HGH secretion to a variety of stimuli can be studied by measuring concentrations of the hormone by the radioimmunoassay.

Basal levels of HGH after an overnight fast range from undetectable levels to 15 mμg/ml. Considerably higher concentrations are usually found in patients with acromegaly. Hypoglycemia is a major stimulus for the secretion of HGH. The insulin tolerance test his been used to produce hypoglycemia and subsequently increased HGH levels in normal subjects. HGH secretion in response to hypoglycemia fails to occur in patients with hypopituitarism. Similarly, an arginine infusion, injection of Piromen®, or muscular exercise can stimulate the secretion of HGH in normal individuals.

Whereas hypoglycemia stimulates HGH secretion, an elevation of the blood glucose can frequently inhibit it. These responses are not seen when an autonomous pituitary tumor is present. Thus, an elevated basal level of HGH, which cannot be suppressed by an oral glucose load, permits the laboratory confirmation of the diagnosis of acromegaly. Similarly, this suppression test may be used to evaluate the course of the acromegalic patient after a given therapy so as to assess accurately the activity or inactivity of the disease process.

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EARLY PERICARDIECTOMY. — Experience during the past decade or more in the treatment of constrictive pericarditis has brought about a more aggressive attitude on the part of clinicians, and especially surgeons. In the light of such experience, the following conclusions may be reached:

(1) Many cases of acute pericarditis, regardless of etiology, will be overlooked.

(2) It is useless to continue ineffective medical management in the face of progressive symptomatology and obvious progressive pericardial enlargement.

(3) Early pericardiectomy is indicated as soon as it is apparent that the patient may be classified as a medical failure.

(4) When operation is performed early in the course of the disease, the technical aspects of the procedure are considerably simplified and the general condition of the patient is such that he can tolerate surgery much better than were the disease allowed to progress to a more chronic state.

(5) Constrictive pericarditis is occasionally associated with similar changes in the pleura, and concomitant pericardiectomy and pleurectomy should be done when indicated.

(6) Satisfactory results can be expected in nearly all cases of pericardiectomy when there has been adequate removal of the constricting pericardium and epicardium, and when performed sufficiently early before the advent of irreversible myocardial damage and heart failure. — Hawley H. Seiler, M. D., Tampa, Fla.: *Southern Medical Journal*, 60:1271, December 1967.

Oral Sodium Tolbutamide Tolerance Test

A Study of Patients with Reactive Hypoglycemia

NASIR ALI, M.D., and C. ROBERT TITTLE, JR., M.D.

ALTHOUGH spontaneous hypoglycemia may result from several causes, the majority of such cases in clinical practice are of the "reactive type," defined as hypoglycemia following ingestion of food with high glucose content. Most other adult patients with spontaneous hypoglycemia have episodes induced by fasting. These include patients with liver disease, insulinoma, endocrine deficiency of the anterior pituitary or adrenal cortex, or starvation with or without the excessive consumption of alcohol.

The precise mechanism responsible for the abnormally low blood sugar in reactive hypoglycemia is not known, but it has been postulated that there is either an excessive response by the islet cells of the pancreas to a glucose load, or that there is an inappropriate delayed secretion of insulin to a normal stimulus, resulting in functional hypoglycemia.

It has been well documented by Seltzer, Fajans, and Conn[1] that spontaneous hypoglycemia of the reactive type may be an early manifestation of diabetes mellitus, and in Harris' pioneer observations of patients with spontaneous hypoglycemia[2] he describes patients with diabetes mellitus and "dysinsulinism." The "alimentary hyperinsulinism" of a small group of postgastrectomy patients has recently been reported to be associated with a high percentage of diabetic type of response to intravenous glucose tolerance testing,[3] and peptic ulcer unoperated has been shown to be associated with an unusual incidence of spontaneous hypoglycemia.[4] Sullivan and Baskell,[5] studying patients with dumping symptoms and reactive hypoglycemia following gastric surgery for peptic ulcer, discovered that 13 of 19 such patients had a diabetic response by the intravenous tolbutamide test.

Recently Sussman et al[6] have reported the measurement of plasma insulin levels during spontaneous reactive hypoglycemia and found that approximately one third of the patients studied exhibited a delayed, inappropriate insulin response to an oral glucose tolerance load, compatible with the metabolic abnormality of an early stage of diabetes mellitus.

The present study is to report the application of the oral modification of the sodium tolbutamide tolerance test as an index of suspected diabetic etiology[7] in 17 adults with spontaneous reactive hypoglycemia. These data are compared to other evidence suggestive of a diagnosis of diabetes mellitus, including the oral glucose tolerance test interpreted by the criteria of Conn and Fajans,[8] an estimation of the "glucose tolerance area index" using the formula for approximation of the area under the two-hour oral glucose tolerance curve as derived by Vecchio et al[9] and a family or obstetrical history compatible with clinical diabetes mellitus.

Method

The patients were selected from an adult medical population during a period of approximately three years. Each had clinical signs and symptoms of spontaneous hypoglycemia plus normal fasting blood sugar. Two hour postprandial blood sugar, which in most cases had not returned to the fasting level, normal liver function by bromsulphalein test, and no clinical evidence of an obvious endocrinopathy.

A standard oral glucose tolerance test was performed in each case on venous blood sugar samples

The Authors

● Dr. Ali, Toledo, is Resident in Internal Medicine, Maumee Valley Hospital.

● Dr. Tittle, Toledo, is Director of Medical Service, Maumee Valley Hospital; Professor of Clinical Medicine, State Medical College of Ohio at Toledo.

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Reprint requests to Department of Medicine, Maumee Valley Hospital, 2025 Arlington Avenue, Toledo, Ohio 43609.

taken fasting, each one half hour for the first two hours, and then hourly for a total of six hours. If significant hypoglycemic symptoms developed between scheduled specimens, a blood sample was drawn at that time. The time of the lowest recorded blood glucose in each case is recorded in Tables 1 and 2, the hypoglycemia level in each case being 45 mg./100 ml. or less "true" blood glucose and accompanied by subjective manifestations of a hypoglycemic state. Spontaneous reversion of the low blood glucose levels toward normal before the completion of the six-hour glucose tolerance test was present in each case.

The oral glucose tolerance, as interpreted by the criteria of Conn and Fajans,[8] was termed diabetic if the one hour value was 160 mg./100 ml. or above, 1½ hour value 140 mg./100 ml. or above, and two hour value 120 mg./100 ml. or above. If one of the values was below these levels, the test was termed "probable diabetes," and if two of the three glucose levels were within normal limits the test was termed "nondiagnostic." The "glucose tolerance area index," an approximation of the area under the two-hour oral glucose tolerance curve, was calculated from the following formula derived by Vecchio et al[9]:

$$\frac{\text{FBS}}{2} + \text{½ hr. BS} + \text{1 hr. BS} + \text{1½ hr. BS} + \frac{\text{2 hr. BS}}{2}$$

Mean value Glucose Tolerance Area Index 408.6 ± 104.8 (S. D.)

The 95th percentile is 563.

This simple calculation offers a convenient means of comparing test results, a close approximation of the resultant of absorption and disposal of the glucose load over the entire two hour period. An oral sodium tolbutamide tolerance test was then performed in each case, as follows:

> "Eight tablets, each containing 250 mg. of sodium tolbutamide and 250 mg. of sodium bicarbonate,* were administered orally after drawing a fasting venous glucose. Further blood glucose samples were taken exactly 30 minutes and 40 minutes after the drug ingestion, and the test was terminated by sweetened fruit juice followed by a good breakfast."

The range of fall of blood glucose in the diabetic vs nondiabetic is expressed as a percentage of the fasting blood glucose as depicted in Figure 1.[7]

In our experience with this test, we agree with others that borderline values are uncommon, and the upper limit of normal for the 30 minute blood glucose specimen was found to be 78 per cent of the pretest value.

The incidence of additional evidence of the diabetic state in the abnormal vs normal tolbutamide reactors was estimated by recording the presence or absence of a family or obstetrical history compatible with diabetes mellitus.

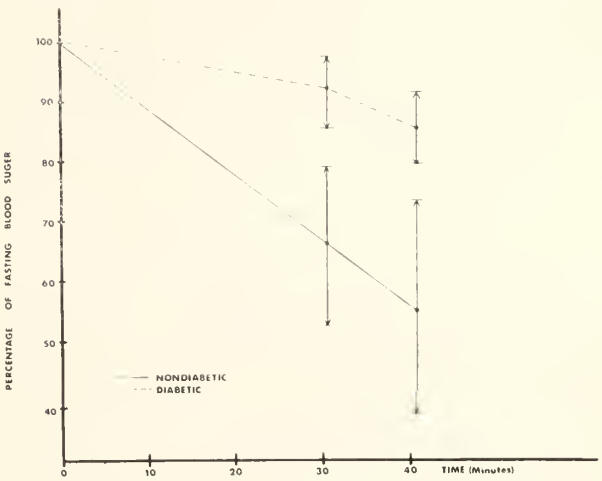


FIG. 1. *Oral Sodium Tolbutamide Test (Criteria for Interpretation)*

Results

Twelve of the seventeen patients with reactive hypoglycemia had abnormal, presumably diabetic, oral sodium tolbutamide tolerance tests (Table 1). It is of interest to note that eight of this group had a diabetic family history and two gave an obstetrical history compatible with this disease. Also, the average time of the recorded hypoglycemic phase of the glucose tolerance curve in this group was 222.5 minutes. The standard oral two hour glucose tolerance test was interpreted as "diabetic" in three cases, "probably diabetic" in five cases, and "non-diagnostic" in four cases. However, the glucose tolerance area index was above the calculated cut off criteria for abnormality of 560[9] in each of the 12 abnormal sodium tolbutamide test reactors.

Conversely, of the five reactive hypoglycemic normal sodium tolbutamide test reactors four had a negative diabetic family history, the average time of the recorded hypoglycemic phase of the glucose tolerance curve in this group was 204 minutes, and the glucose tolerance area index was less than 560 in each case (Table 2).

Discussion

Spontaneous hypoglycemia of the so-called reactive type, although probably of multiple etiologies, is an early manifestation of diabetes mellitus in some patients with this complaint. Detection of the diabetes

* Oral sodium tolbutamide for these tests was generously supplied by Dr. Thomas Vichio from the Upjohn Company, Kalamazoo, Michigan.

in this group should be valuable not only as a prognostic aid but perhaps even more so as an opportunity to provide a therapeutic regimen designed to postpone the progression to overt diabetes and its complications. The interpretation of the standard oral glucose tolerance test in minimal degrees of carbohydrate intolerance is frequently difficult, and a definite distinction between normal and abnormal is assigned only on a probability basis. The estimation of the area under the glucose tolerance curve as described by Vecchio et al and applied to the glucose tolerance data in this report may offer a more convenient means of comparing test results in borderline glucose tolerance abnormalities.

If we accept the premise of Unger and Madison[10] that the short term intravenous sodium tolbutamide tolerance test has greater specificity and reproducibility than the oral glucose tolerance test in the diagnosis of "minimal" diabetes, we can, based upon previous studies,[11] agree with reports that the recent oral modification of this test produces comparable results with greater convenience and less hazard of hypoglycemia.

Therefore, it would seem logical that the oral sodium tolbutamide tolerance test might prove to be a reliable practical diagnostic aid in detecting those cases of spontaneous reactive hypoglycemia of diabetic etiology.

The application of this test to this short series of cases of reactive hypoglycemia revealed abnormal sodium tolbutamide tolerance in 12 of 17 so tested, correlating positively with other presumptive evidence of the diabetic state, including a positive family history or obstetrical history, a recorded hypoglycemic phase of the oral glucose tolerance test usually closer to the fourth hour of the test when compared with an earlier onset of hypoglycemia in the normal tolbutamide reactors, and a "glucose tolerance area index" estimation in the diabetic range in each case. These correlations would seem to be of more specific diagnostic value in this series than the standard interpretation of the oral glucose tolerance test.

If the reliability of the oral sodium tolbutamide tolerance test in the diagnosis of minimal diabetes mellitus survives the test of time, its application to cases of spontaneous reactive hypoglycemia should have diagnostic significance and perhaps treatment implications as well. Sullivan and Boshell[5] have reported amelioration of dumping symptoms following gastric surgery for peptic ulcer by the use of oral sodium tolbutamide before meals in those patients who demonstrated a diabetic type of response to the sodium tolbutamide test. Our preliminary experience

Table 1.-- Reactive Hypoglycemia with Abnormal Sodium Tolbutamide Tolerance

Age	Sex	Lowest Blood Glucose (mg/100ml)	Time of Lowest Blood Glucose (min.)	Oral Glucose Tolerance	Glucose Tolerance Area Index*	Diabetic Family History
46	M	43	240	Probable Diabetes	573	Positive
58	M	38	240	Diabetic	608	Negative
56	M	42	240	Probable Diabetes	596	Negative
36	M	40	240	Diabetic	644	Positive
46	M	38	210	Non-diagnostic	601	Negative
34	F	40	240	Probable Diabetes	587	Positive Obstetrical
36	F	42	180	Non-diagnostic	583	Negative
53	M	44	240	Probable Diabetes	629	Positive
44	M	42	210	Non-diagnostic	584	Positive
56	F	40	240	Diabetic	611	Positive
42	F	38	210	Probable Diabetes	602	Positive & Positive Obstetrical
52	F	42	180	Non-diagnostic	582	Positive

*Area Index mean value=408.6±104.8 S.D. (Vecchio et al)

Table 2.-- Reactive Hypoglycemia with Normal Sodium Tolbutamide Tolerance

Age	Sex	Lowest Blood Glucose (mg/100ml)	Time of Lowest Blood Glucose (min.)	Oral Glucose Tolerance	Glucose Tolerance Area Index*	Diabetic Family History
43	M	45	180	Probable diabetes	549	Negative
45	F	44	240	Non-diagnostic	541	Negative
43	F	42	180	Non-diagnostic	551	Negative
56	F	42	180	Non-diagnostic	549	Negative
42	M	42	240	Diabetic	558	Positive

*Area Index mean value=408.6±104.8 S.D. (Vecchio et al)

with the use of oral sodium tolbutamide before meals in patients with spontaneous reactive hypoglycemia, has revealed similar amelioration of the hypoglycemic symptoms in four of seven cases among the abnormal sodium tolbutamide test reactors, but problems of dosage and timing of drug ingestion prior to meals have not as yet been resolved.

Summary

In this study of the application of the oral sodium tolerance test in cases of spontaneous reactive hypoglycemia, 12 of 17 such patients had an abnormal, presumably diabetic response. The abnormal responders revealed better correlative evidence of a diabetic state than the nonresponders, and the test results were frequently more distinctly normal or abnormal than the interpretation of the standard oral glucose tolerance test.

We propose that the oral sodium tolbutamide tolerance test should be helpful in differentiating the diabetic vs nondiabetic patients presenting with spontaneous reactive hypoglycemia. This information may have both diagnostic significance and treatment implications.

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GLYCOSURIA OF PREGNANCY. — In view of the almost uniform finding of glycosuria in pregnancy if sought by efficient methods, and in view of the low incidence of diabetes in pregnancy (0.28 per cent in the series studied), it is recommended that glucose-tolerance tests with blood-sugar curves be replaced by routine blood-sugar estimations one hour after a meal or better still after 50 g. of oral glucose. It should be done in all multiparae, whether found glycosuric or not, in conjunction with other tests usually required at antenatal clinics; in primiparae it should be done only where clinically indicated. — J. Fine, M.D., D.P.H., D.T.M., Kitwe, Zambia: *British Medical Journal,* 1:205-210, January 28, 1967.

The Zoonoses in Ohio, 1958-1962

PAUL R. SCHNURRENBERGER, D. V. M., M. P. H., RALPH A. MASTERSON, D. V. M., M. P. H., and JACK H. RUSSELL, D. V. M., M. P. H.

THE zoonotic diseases occupy a unique position in the spectrum of human disease in that they affect lower animals primarily and man only secondarily. Because of this epidemiologic peculiarity and the diagnostic problem they present to the practicing physician, the Ohio Department of Health has established the policy of conducting an epidemiologic investigation of each case brought to their attention. The present report covers the cases of brucellosis, leptospirosis, psittacosis, and trichinosis with onset from January 1, 1958, through December 31, 1962.

Receipt of a morbidity report card or positive laboratory report initiated a visit to the local health department to obtain clearance for investigation. The attending physician was then consulted for a clinical description of the disease and permission to interview the patient. The epidemiological information was gathered from the patient. When indicated, samples for laboratory analysis were obtained from animal contacts.

Brucellosis

Twenty-two cases of brucellosis were reported during the five year period (Table 1), with the majority occurring during late spring and early summer. Five of the cases were from Lorain and Cuyahoga Counties with over one third of the five year total located in five contiguous northeast counties (Figure 1).

The cases were characterized by fever, chills, sweating, myalgia, and arthralgia with individual cases reporting abortion, orchitis, and unilateral paralysis.

Males were reported twice as commonly as females (Table 3) and three fourths of the cases where the age was known were between 20 and 60 years (Table 4). Although sexually immature persons are felt to be somewhat more resistant to brucellosis, this is probably a reflection of the occupational nature of brucellosis (Table 5). Although eight of the cases were traced to exposure to infected cattle, none showed evidence of contracting their infection from swine. Only one case was felt to be due to drinking unpasteurized milk. A veterinarian's assistant was infected through accidental inoculation with Strain 19 vaccine.

From the Division of Communicable Diseases, Ohio Department of Health, Columbus, Ohio. Submitted June 8, 1967.

The Authors

- **Dr. Schnurrenberger, Springfield, Illinois, formerly with the Ohio Department of Health, Columbus, presently is Chief Public Health Veterinarian, Illinois Department of Public Health.**
- **Dr. Masterson, Columbus, is State Epidemiologist with the Ohio Department of Health.**
- **Dr. Russell, Columbus, is Chief Public Health Veterinarian, Ohio Department of Health.**

Leptospirosis

There was a marked seasonal pattern to the onset of leptospirosis cases with two thirds occurring in July, August, and September. This pattern did not vary among the three serotypes. The only remarkable geographic facet was the lack of reported cases in the southeast quarter of Ohio.

Leptospirosis is the only one of the four diseases described here which has a significant number of cases among nonwhites (Table 3). All of the six cases in nonwhites appeared to be due to *Leptospira icterohemorrhagiae* on the basis of serological studies. Three of the six apparently had contracted their infection from rats, one from a dog, one from stagnant water, and one unknown.

Direct contact with animals was reported commonly, with dogs as the source of five cases of *L. canicola* and five of *L. icterohemorrhagiae*. Rat contact was directly responsible for at least four cases of *L. icterohemorrhagiae* and cattle for four cases of *L. pomona*. Four cases had contact with stagnant water which could have become contaminated with the urine of rats or other wild mammals.

The clinical syndrome was quite similar among the three serotypes encountered. The symptoms in descending order were fever, headache, vomiting, nausea, myalgia, chills and nuchal rigidity. Icterus

was reported in only seven patients, six due to *L. icterhemorrhagiae* and one due to *L. canicola*. The average hospital stay was 10 days regardless of the serotype involved. The three fatal cases were all due to *L. icterohemorrhagiae,* males, and over 50 years of age. Two of the three were negro.

L. canicola is the least occupationally centered of the three leptospiral infections described here, since it is usually contacted from the family pet. This is demonstrated by the younger ages of the patients in this group (Table 4).

There were three instances where two cases appeared concurrently. Two Butler County children contacted *L. canicola* from their pet dog. A father and son from Champaign County had concurrent infections of *L. icterohemorrhagiae* from an undetermined source. A veterinary meat inspector and an abattoir worker in Defiance County were ill with *L. pomona* at the same time. The exact source could not be determined but the two worked side by side in the plant.

Psittacosis

Although only 11 cases of psittacosis were reported, they illustrate the changing pattern of this disease. The four cases in 1958 and 1959, where the

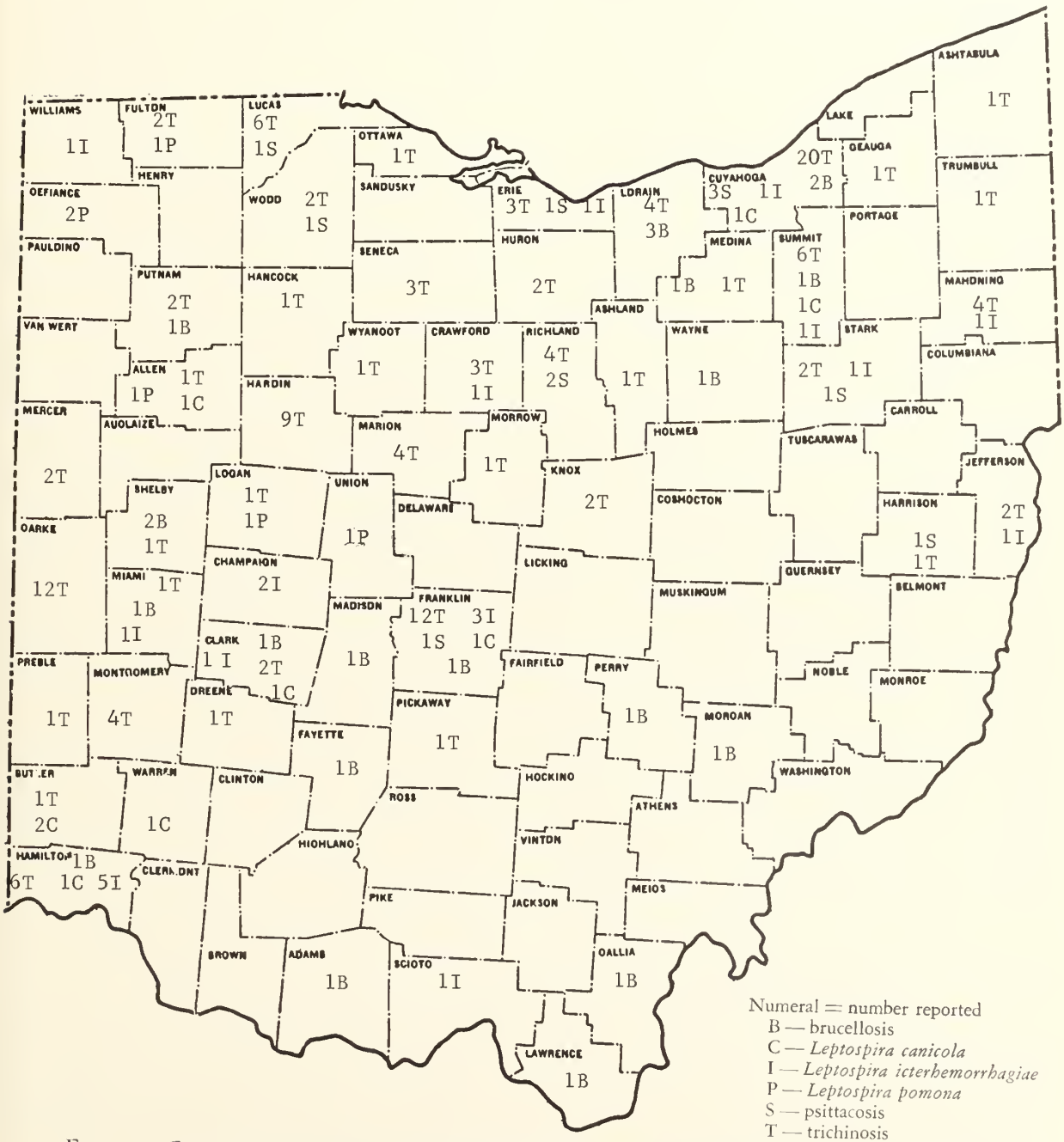


FIG. 1. *Geographic Distribution of Reported Zoonotic Infections in Man, 1958-1962.*

source of infection could be determined, were all due to parakeet contact. The increasing use of chlortetracycline impregnated parakeet feed during these same years markedly reduced the infection rate among parakeets. The only case with parakeet contact since 1959 was a woman in 1962 who owned two birds. The birds were destroyed but psittacosis virus was not isolated from their organs.

The case in 1960 involved a laborer with a great deal of pigeon contact in the course of his work. Two cases in 1962 pertained to pigeon fanciers and a third was a church caretaker who became ill shortly after ridding the church belfry of pigeons.

The most common symptoms were fever, chills, respiratory distress or cough, headache and sweating.

Trichinosis

Trichinosis was by far the most commonly reported of these four diseases with a total of 136 described here. Excluded from this report is a 1958 institutional outbreak of over 60 cases which has been described elsewhere.[1]

Both the seasonal and geographical patterns of trichinosis are distorted because of the frequency of outbreaks. The case distribution, however, tends to resemble more closely the distribution of the population since it does not involve direct animal contact but instead reflects dietary habits. This difference in mode of infection is also reflected in the fact that this is the only one of the four diseases with a preponderance of females.

The occupational aspect of trichinosis is seen in the 17 cases resulting from tasting raw sausage while cooking.

The most common symptoms were fever, periorbital edema, myalgia, eosinophilia, and diarrhea. Although splinter hemorrhages are often considered a cardial sign of trichinosis, they were reported in only one case in this series.

Information on hospitalization was available on 77 persons, 14 of whom were not hospitalized. The others ranged from 3 to 48 days with the mode 6 to 8 days. Seven were hospitalized for more than 30 days. Two deaths occurred, a 65 year old woman and a 77 year old man. Twenty-one of the cases were confirmed by biopsy.

Although the incubation period was stated in only 14 investigations, there was an inverse relationship between incubation period and duration of hospital stay. The mean incubation period for those hospitalized less than a week was 24 days, for those hospitalized 8 to 21 days it was 19 days, and for those hospitalized over three weeks it was 13 days.

Fifty-nine were infected from sausage but it was not always stated in the report whether this was fresh, smoked or a summer sausage. Eleven cases occurred in one outbreak in Darke County following the consumption of "head cheese." All meats used in this product were thoroughly cooked, but they were then processed through a grinder which had just been used to grind fresh pork and which had not been cleaned. Ten single cases were the result of incompletely cooked roasts or chops and seven

TABLE 1. *Annual Reporting of Selected Zoonotic Diseases in Ohio*

	1958	1959	1960	1961	1962	Total
Brucellosis	5	6	7	1	3	22
L. canicola	3	3	–	3	–	9
L. pomona	4	2	–	–	–	6
L. icterohemorrhagiae	3	7	3	3	5	21
Psittacosis	3	2	1	–	5	11
Trichinosis	30	19	26	32	29	136

TABLE 2. *Month of Onset of Reported Cases of Zoonotic Diseases in Ohio, 1958-1962*

Month of Onset	Brucellosis	Leptospirosis	Psittacosis	Trichinosis
January	–	1	–	8
February	1	2	1	10
March	2	–	–	9
April	1	1	–	23
May	2	1	4	4
June	6	2	1	6
July	3	7	1	6
August	1	12	–	12
September	1	5	–	5
October	–	3	1	7
November	1	2	1	7
December	2	–	1	15
Unknown	2	–	1	24
Total	22	36	11	136

TABLE 3. *Sex and Race Distribution of Reported Zoonosis Cases in Ohio, 1958-1962*

	Brucellosis	Leptospirosis	Psittacosis	Trichinosis
Male				
White	14	26	7	47
Nonwhite	–	5	1	2
Unknown	1	–	–	8
Female				
White	6	4	3	69
Nonwhite	–	1	–	2
Unknown	–	–	–	4

TABLE 4. *Age Distribution of Reported Zoonotic Infections in Ohio, 1958-1962*

	1-9	10-19	20-29	30-39	40-49	50-59	60-69	70+	Unk.
Brucellosis	1	1	4	3	3	3	1	1	5
L. canicola	3	3		1	1		1	–	–
L. pomona	1	1	1	3	–	–		–	–
L. icterohem.	1	6	5	1	3	4	–	1	–
Psittacosis				3	2	4	–	–	2
Trichinosis	1	9	20	22	22	30	8	4	20

TABLE 5. *Occupation of Reported Zoonosis Cases in Ohio, 1958-1962*

	Brucellosis	Leptospirosis	Psittacosis	Trichinosis
Farmer	6	4	–	1
Butcher	4	3	–	2
Veterinarian	3	1	–	1
Aviary Owner	–	–	3	–
Student	1	13	–	2
Housewife	–	3	2	19
Professional	1	–	–	5
Blue Collar	–	1	1	7
Laborer	–	8	3	8
Unemployed	–	1	–	2
Unknown	7	2	2	89

were traced to ground beef. It could not be determined whether the beef had been intentionally diluted with pork or whether it was accidentally contaminated in the grinding process.

In addition to the Darke County outbreak, there were two instances of concurrent infection in husband and wife, four neighborhood outbreaks involving four, five, six, and seven cases respectively.

Discussion

The strong occupational overtones of most of the zoonotic infections provide a valuable aid for the physician faced with the task of assigning a specific diagnosis to a nonspecific set of symptoms such as those described in this report. These epidemiologic guides to diagnosis, when recognized and supported by serologic confirmation, can often mean the difference between another fever of unknown origin and the solution of a diagnostic problem.

Prompt reporting of the suspected diagnosis followed by an epidemiological investigation to determine the source can do much to prevent future cases. This group of diseases is unique in that to control them in man, we must first control them in animals. Defining the problem and pinpointing sources and modes of infection is the first step toward effective control procedures in animals and man.

Summary

From 1958 to 1962, there were 22 cases of brucellosis; 11 of psittacosis; 36 of leptospirosis; and 196 of trichinosis reported by practicing physicians and investigated by the Ohio Department of Health.

This group of diseases is rarely transmitted from man to man but has animal sources. For this reason careful history taking can provide important diagnostic aids as well as pinpointing reservoirs for future infections.

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SNAKEBITE. — An estimated 1,130 people are bitten by rattlesnakes annually in the Eastern United States. This provides an incidence of 9.5 bites per million population per year. With an average of 6 deaths per year from rattlesnake bites in this area, the case-fatality rate is quite low, about 0.53 per cent. Of an estimated 1,130 rattlesnake bites, 449 were inflicted by timber rattlesnakes *(C. horridus)*, 294 by eastern diamond rattlesnakes *(C. adamanteus)*, 292 by pigmy rattlesnakes *(S. miliarius)*, 89 by eastern massasaugas *(S. catenatus)*, and 6 other species of rattlesnakes not native to the Eastern United States.

States having the highest rates of rattlesnake bites per million population per year are: Georgia—71.0; Florida—52.3; Mississippi—49.6; South Carolina—41.1; Alabama—31.2; and North Carolina—16.9. Males had higher rates of bites than females and persons 10 to 29 years of age had high rates. Most of the bite accidents happened from April through October. Ninety-four per cent of the bites were inflicted on the victims' extremities; 41 per cent on the upper and 53 per cent on the lower extremities. A higher percentage of cases of severe venenation was associated with bites by large rattlesnake species *(Crotalus sp.)* than with bites by pigmy rattlesnakes and massasaugas *(Sistrurus sp.)*.

The treatment recommended included incision and suction, "the 3 A's" (antivenin, antibiotics and antitetanus prophylaxis), and general supportive measures. — Henry M. Parrish, M. D., and Gerald H. Wiechmann, Ph. D., Columbia, Mo.: *Southern Medical Journal*, 61:126, February 1968.

Electrocardiographic-Pathologic Conference

Left Bundle Branch Block

RALPH C. SCOTT, M.D.*

THE FORMAT of the electrocardiographic-pathologic conference (EPC) has been presented in the first article in this series.[1]

Electrocardiographic Interpretation

The electrocardiogram illustrated in Figure 1 was recorded on February 15, 1967. The QRS measures 0.13 sec. in duration. No Q waves are present in lead I or leads V_5 or V_6. There is abnormal left axis deviation of –40°. There is early notching of the downstroke of the QS deflection in lead III and early slurring of the downstroke of the S wave in lead V_3. The R waves in V_1 and V_2 measure approximately 2 mm. in height but measure only 0.5 mm. in height in V_3. Atrial fibrillation is present. This electrocardiogram shows a rather typical pattern for complete left bundle branch block with abnormal left axis deviation. Although it may not be readily apparent in the reproduction, in the original electrocardiogram the QRS configuration in V_4 consists of an rsR′S′.

It has been demonstrated that in the presence of complete left bundle branch block the conventional voltage criteria for left ventricular hypertrophy are not valid, although well over 90 per cent of the cases of left bundle branch block that have been studied at autopsy do have anatomic left ventricular hypertrophy.[2]

In the presence of left bundle branch block progressive diminution in height of the R wave in the right and mid precordial leads is not a reliable sign for the diagnosis of myocardial infarction;[3] therefore, this diagnosis is not suggested.

Summary:

1. Complete left bundle branch block
2. Abnormal left axis deviation
3. Atrial fibrillation
4. Left ventricular hypertrophy (by inference)

Clinical Resumé

This 78 year old white man was admitted to the Cincinnati General Hospital on February 14, 1967. He had been brought to the hospital by the police because of weakness, confusion, and shortness of breath. On admission he was cyanotic. His blood pressure was 120/85; the pulse was 94 beats per minute and grossly irregular. The venous pressure was elevated and the heart was enlarged to the anterior axillary line. The chest x-ray demonstrated cardiomegaly and bilateral pleural effusions. The lower extremities were edematous, erythematous and cold.

A history of hypertension could not be obtained. There was, however, a history of previous therapy with digitalis for congestive heart failure.

He was treated in the hospital with digitalis, diuretics, and bronchodilators. Thoracentesis yielded a transudate. On the second hospital day he spiked a temperature of 102 F and his course thereafter was rapidly downhill. He died on February 18, 1967.

Necropsy Findings

The heart weighed 540 Gm. fresh, 515 Gm. after fixation, and 427 Gm. after epicardial fat removal. The left coronary artery was large and dilated with no significant narrowing. There were, however, atheromata in the wall. The right coronary artery showed focal 35 per cent narrowing 4 cm. from the ostium. The left ventricular myocardium showed mild interstitial fibrosis especially in the high posterior wall. There was marked left ventricular dilatation and moderate right ventricular dilatation with marked left ventricular hypertrophy. The ventricular weights were: left ventricle (LV) 181 Gm.; interventricular septum (S) 85 Gm.; right ventricle (RV) 58 Gm. The (LV + S)/RV ratio was 4.6 (normal 2.1 to 3.6) with the heart in the pure left ventricular hypertrophy category. In addition there was severe biatrial dilatation. The pathologic diagnoses were:

1. Left ventricular hypertrophy, severe, pure
2. Left ventricular dilatation, marked
3. Interstitial fibrosis, mild

Comments

This case illustrates some of the diagnostic problems encountered by the electrocardiographer in the presence of left bundle branch block. The electrocardiogram as illustrated in Figure 1 shows a rather typical configuration for left bundle branch block. It has been suggested by Grant[4] that abnormal left axis deviation is not part of the picture of uncomplicated left bundle branch but, is seen only when it

From the Cardiac Laboratory, Cincinnati General Hospital and the Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. Submitted January 30, 1968.

*Dr. Scott, Cincinnati, is Associate Professor of Medicine, University of Cincinnati College of Medicine, and Director of Cardiac Clinics, Cincinnati General Hospital.

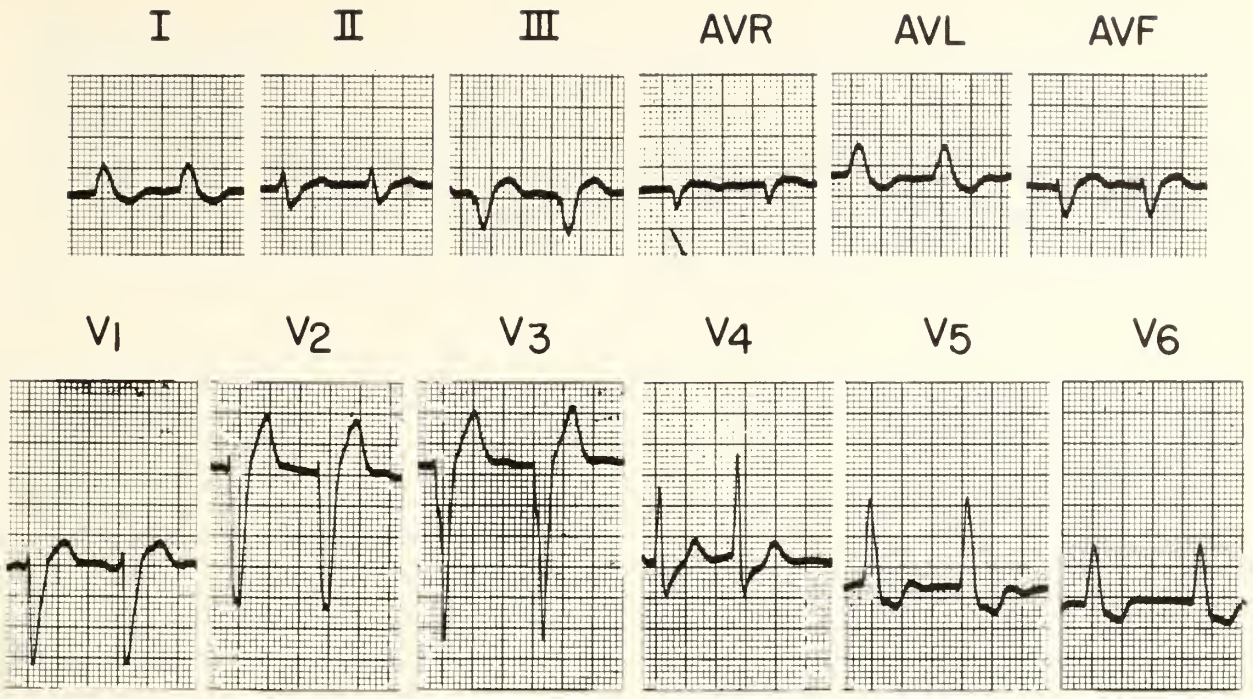


FIG. 1. *Electrocardiogram recorded on 2/15/67. This tracing shows complete left bundle branch block, abnormal left axis deviation and atrial fibrillation. Note that there is progressive diminution in height of the R Waves between precordial leads V_1 and V_3.*

was present prior to the development of the block. Although these observations are interesting this has not always been the case in our experience. We have observed some cases prior to the development of left bundle branch block that have not displayed preexisting abnormal left axis deviation.

As noted above, the conventional voltage criteria for the diagnosis of left ventricular hypertrophy should not be applied to the electrocardiogram displaying left bundle branch block. However, since it has been demonstrated that nearly all cases coming to autopsy with left bundle branch block do display anatomic left ventricular hypertrophy,[2] such an inferential diagnosis seems permissible.

Progressive diminution in the height of the R wave or even loss of the R wave in the right or mid precordial leads ordinarily suggests the possibility of an anteroseptal myocardial infarction. However, this sign is not valid in the presence of left bundle branch block since it may frequently occur in this condition and, as in this case, no autopsy evidence of infarction can be demonstrated.[3] This may be referred to as one of the pseudo-infarction patterns occurring in left bundle branch block. On the other hand it should be noted, however, that anatomically proven myocardial infarction in the presence of left bundle branch block may exhibit such an abnormal R wave progression in the right precordial leads.[5]

Acknowledgments: The author wishes to express his thanks to Dr. Sandra Conradi who performed the detailed necropsy examination in this case, and to Dr. Robert J. Norris and Dr. Emmett Conyers for their participation in the electrocardiographic and clinical correlation.

Supported in part by Public Health Service Research Grant No. HE-08578. Additional support was received from the Heart Association of Southwestern Ohio, Inc.

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Heart Page

Peripheral Vascular Disease

V. Arterial Aneurysms

RAY W. GIFFORD, JR., M.D.

ANEURYSMS of the aorta, iliac, femoral, and popliteal arteries pose a much greater threat to life and limb than does atherosclerotic occlusive disease of these vessels. Consequently, in undertaking surgical removal of such aneurysms greater risks must be assumed than are justified in the operative management of occlusive disease.

Most aneurysms are atherosclerotic in origin, but they are not necessarily associated with occlusive disease. The diagnosis of aneurysms of the abdominal aorta, iliac, femoral, and popliteal arteries is usually made by palpating a pulsatile mass. Sometimes the diagnosis is first suspected from roentgenographic demonstration of curvilinear calcification in the wall of the aneurysm. The diagnosis of thoracic aortic aneurysms is usually made from roentgenograms of the chest.

It is axiomatic that most aneurysms are asymptomatic until (1) they become large enough to exert pressure on contiguous structures, (2) they start to leak, or (3) they produce signs and symptoms of arterial occlusion due to thrombosis locally or embolization of thromboatheromatous material distally. Once an aneurysm becomes symptomatic there is immediate threat to the survival of the patient and/or his limb, and the risk of operation concomitantly increases.

The risk of aneurysms of the aorta is chiefly that of rupture; less often they give rise to microemboli that produce ischemic lesions of the skin of the feet and legs. Fewer than 20 per cent of patients with abdominal aortic aneurysms and fewer than 30 per cent of patients with thoracic aortic aneurysms survive five years after diagnosis, and most die from rupture of the aneurysms. Aneurysms of the iliac artery constitute a similar threat. Abdominal aortic aneurysms seldom rupture until they are larger than 7.5 cm. It seems reasonable, therefore, to adopt the policy of deferring resection of small aneurysms of the abdominal aorta until they begin to enlarge, especially when patients also have vascular insufficiency of the brain or mycocardium, because progress studies have shown that patients with symptomatic coronary and/or cerebral vascular disease are more likely to die from stroke or coronary insufficiency than from rupture of a small aneurysm. However, resection should be accomplished before the aneursym becomes symptomatic and the risk has increased several fold.

The risk of popliteal and femoral aneurysms is chiefly that of thrombotic and/or embolic occlusion. The amputation rate for patients with untreated popliteal aneurysm is about 20 per cent within three years of diagnosis. These aneurysms can be resected with little threat to life or limb.

For unknown reasons, aneurysms of the splenic and renal arteries are prone to rupture during pregnancy. With this exception, splenic and renal aneurysms rarely lead to complications, and their routine removal is not justified. Aneurysms of the renal artery usually do not produce severe hypertension unless there is associated occlusive disease.

A dissecting aneurysm of the aorta is a catastrophic event that usually begins in the ascending thoracic aorta. The mortality rate is 25 per cent within 24 hours after onset of symptoms, and 40 per cent within 48 hours. The risk of surgical repair of acute dissecting aneurysm is so great that medical treatment, employing parenteral administration of hypotensive drugs, to keep the blood pressure at low normotensive levels seems preferable.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio.



NEWS AND Organization Section

Proceedings of The Council...

Report of Matters Discussed and Actions Taken at Meeting in OSMA Office, Columbus, February 17-18

A MEETING OF The Council of the Ohio State Medical Association was held in the headquarters office, Columbus, February 17-18, 1968. All members of The Council were present on February 17. Others attending the meeting were: Dr. John H. Budd, Cleveland, Chairman, Ohio delegation to the AMA; Mr. David B. Weihaupt, Chicago, AMA field representative; Dr. Robert E. Tschantz, Canton, AMA Delegate and chairman of the OSMA-OMI Liaison Committee; Dr. Edmond K. Yantes, Wilmington, President of Ohio Medical Indemnity, Inc.; Mr. Wayne E. Stichter, and Mr. Roger Smith, Toledo, OSMA Legal Counsel; Mr. James S. Imboden, Columbus, Field Representative of the American Medical Political Action Committee; and Messrs. Page, Edgar, Gillen, Campbell, and Moore of the OSMA staff.

Those present on Sunday, February 18, were: All members of The Council except Dr. James L. Henry, Grove City, Treasurer, and Dr. Frederick T. Merchant, Marion, Councilor of the Third District; Mr. Roger Smith, Toledo, OSMA Legal Counsel; Dr. Budd; Mr. Weihaupt; Mr. Imboden; and Messrs. Page, Edgar, Campbell, and Moore of the OSMA staff.

Minutes Approved

The minutes of the meeting of The Council, held December 9, 1967, **were approved** by official action.

Membership

Mr. Page reported that as of December 31, 1967, OSMA members numbered 10,131, of whom 8,851 were members of the American Medical Association.

The effect of temporary licensure, established in two categories by H. B. 418, 107th Ohio General Assembly, was discussed as it relates to membership in the Ohio State Medical Association and county medical societies. The Council instructed the legal counsel to draft appropriate changes in the OSMA Bylaws to meet problems involving temporary licensure and membership, and that these provisions be submitted to the House of Delegates in May, 1968.

By official action, The Council reduced the OSMA dues for Anita Ausenbachs, Cuyahoga County, to $15 and dues for J. F. Cava, Jefferson County, were waived, in accordance with Section 1, Chapter 2 of the Bylaws. Such adjustments are effective for 1968

A progress report from the Ad Hoc Committee on Membership was presented by the chairman, Dr. William R. Schultz.

The Council requested that the Membership Department of OSMA furnish to each Councilor, as soon as possible, a list of OSMA members in each respective district, who have not joined the American Medical Association.

Auditing and Appropriations Committee

Council **approved** an appropriation for $75 to buy a full-page advertisement in the annual meeting program of the Ohio State Society of Medical Assistants.

In answer to a request for funds from the Ohio Farm and Home Safety Committee, Council appropriated $50 for this activity.

The Council **approved** the recommendation of the Auditing and Appropriations Committee that up to $1,000 be appropriated to investigate the possibility of a trust fund to finance retirement trusts now existing and the Employee Pension Plan. Further, that a study of the feasibility of erecting a head-

quarters building with the trust fund and leasing it to the OSMA for office space **be approved.**

The Council **approved** a recommendation of the committee that the purchase of a new postage machine be authorized if the equipment proves to be adequate for metering and sealing Annual Meeting programs and other booklets.

By official action, The Council **approved** the following Auditing and Appropriations Committee report on Dues Collection Study as Requested by Resolution No. 6, May 17, 1967, House of Delegates.

Report on Resolution No. 6 1967 House of Delegates

"Members of the Auditing and Appropriations Committee heard witnesses from Hamilton, Summit, Montgomery, Franklin, and Jefferson Counties, and reviewed communications from Mahoning and Lucas Counties. The representatives from Hamilton and Summit expressed concern about cost factors and financing problems. Consideration of reimbursement for dues collection was requested by Hamilton, Summit, and Lucas Counties. Hamilton County requested installment billing be authorized. Only Hamilton, Summit and Lucas Counties expressed opposition to current billing procedures, while Franklin, Jefferson, Mahoning, and the late Mr. R. Freeman, Executive Secretary, representing Montgomery County, found no objection to the present system of having a county bill for local, state, and national association dues.

"The committee felt that insufficient evidence was presented to justify alteration of current billing mechanisms to permit reimbursement to a county for collection of dues or to compensate a county for the time required to explain the dues statement. Explanation of dues is a part of the internal public relations of any organization.

"The Auditing and Appropriations Committee, therefore, recommends that The Council adopt the following four principles in response to the request of the House of Delegates Resolution.

"1. That there be no separate billing for county, state, and national dues.

"2. That combined billing of county, state, and AMA dues by OSMA not be considered at this time, but that the operation of such a program in two neighboring states be observed closely by The Council.

"3. That the cost of dues collection be borne by the county society as is stipulated in their charters.

"4. That the timing or method of dues collection can be programmed by a county society as best suits the needs of its members provided that delinquent dues payment to OSMA and AMA does not jeopardize full membership representation in those bodies."

Councilor Reports

The Councilors reported the activities in their respective councilor districts.

Regional Medical Programs

The Executive Secretary was authorized to furnish to Dr. Neil C. Andrews, Program Coordinator of the Ohio State Regional Medical Program, a tape listing names and addresses of members in the 61 counties covered by such program. A request from the Northwestern Ohio Regional Medical Program for a list of members in Erie and Huron Counties was referred to the secretaries of each county for reply. It was announced that Ohio has four regional programs: Ohio State covering 61 counties; Cincinnati, four counties; Cleveland, 13 counties, and Toledo, 20. Ten of the counties in the Ohio State program are claimed by other regions: All programs are in a planning stage and the operational stage is anticipated. The Ohio State program has three task forces in the fields of heart disease, cancer, and stroke. These are headed by Drs. Robert Kirk, Stuart Roberts, and John Melvin (in that order), all of Columbus. The Ohio State program will have 12 local planning committees.

Welfare Department

In answer to a letter from N. M. Camardese, M. D., dated January 16, 1968. The Council was advised by its legal counsel that the State of Ohio cannot be sued without its consent. By official action, The Council instructed that there be prepared a factual report to the membership, with copies to the Department of Welfare and the Governor's office, fully outlining what has been attempted to solve the welfare department situation, and of the present relationship. Such document is to be prepared following the County Society Officers' Conference, February 25.

Amendments to County Bylaws

Proposed amendments to the Bylaws of the Trumbull County Medical Society, involving a raise in dues, were submitted to The Council. Such amendments **were approved**, subject to the provision that the amendments be restated, in accordance with language outlined by the OSMA legal counsel.

The American Medical Association

Dr. John H. Budd, chairman of the Ohio delegation to the AMA, reported on plans for the June meeting in San Francisco.

A resolution requesting that interim sessions of the House of Delegates be held in Chicago will be introduced by the Ohio delegation.

Council instructed the Executive Secretary to certify ten delegates and ten alternates for the June 1968 meeting of the AMA and voted that the expenses of all delegates and alternates elected by the Ohio State Medical Association House of Delegates be paid, whether or not all are seated by the American Medical Association. It was suggested that the delegates and alternates most recently elected to office be certified last on the list.

The chairman of the Ohio delegation was authorized to make an attempt to compel the American Medical Association to seat all ten Ohio delegates under the rules.

It was determined by The Council that the AMA delegates and alternates seeking election and re-election at the OSMA Annual Meeting in May, will run at large for the four delegate and alternate openings available. It was directed that to be valid, a ballot shall contain as many names as offices contested and that the first four candidates to receive a majority of all votes cast would be declared elected, in accordance with Chapter 5, Section 3 of the Bylaws.

Ohio Medical Indemnity

Dr. Yantes, President of Ohio Medical Indemnity, Inc., addressed The Council, concerning current developments in the operations of that company. By official action, The Council expressed thanks to Ohio Medical Indemnity for the promptness and completeness of the work of the special committee appointed to look into the matter of presenting to county medical society mediation (or review) committees, mechanisms for defining usual, customary, and reasonable and ethical fees. This report was distributed to The Council.

The Council again affirmed the fact that the Liaison Committee, as presently established, is the proper committee to represent The Council of the Association in matters relating to Ohio Medical Indemnity, Inc. The report of a meeting of the OMI Liaison committee, held February 16, 1968, was approved.

1968 Annual Meeting

Mr. Campbell presented a progress report on the 1968 Annual Meeting. The Council authorized additional expenditures for food to be served at the Gaslight Party and instructed Mr. Campbell to prepare certificates for scientific exhibitors to be awarded in addition to the exhibit plaques and asked that the president write a letter of thanks to all scientific exhibitors.

Three resolutions which have been submitted for the Annual Meeting were reviewed by The Council. The Councilor of the Eleventh District was requested to communicate with the Erie County Medical Society concerning the correction of a mis-statement in the final resolve of a resolution submitted by that society.

The Council accepted, for information, the results of a survey conducted by the Architects Society of Ohio, with regard to professional convention practices and experience.

The Council approved the formation of a Section on Rheumatology and expressed no objection to the organization of an Ohio Rheumatism Society.

The proposed publication of an Annual Meeting booklet "The Conventioneer" was disapproved.

Abortion Laws

The Council then discussed proposals for a debate on liberalizing abortion laws for *The Ohio State Medical Journal;* a poll of the membership concerning opinions with regard to liberalizing abortion procedures, and an Annual Meeting exhibit on the question of liberalizing abortion laws. All three proposals were disapproved, since a specific policy has already been established by a House of Delegates' resolution in May, 1965, a policy which outlines in detail a legislative proposal which may be offered to the Ohio General Assembly on behalf of the Association.

Legislation

The Council confirmed a letter of January 4, 1968, written by the Executive Secretary to the Hon. Clarence J. Brown, Jr., Member of Congress, with regard to the expression of OSMA opinion on legislation to control the manufacture, possession, and use of LSD and other "mind-expanding" drugs.

Mr. Page discussed plans for the 1968 Washington Visitation, June 5, and asked the members of Council to follow up to make certain that members of the State Legislative Committee in their districts make appointments with their Congressmen for the morning of June 5.

Dr. Meredith was asked to attend the meeting and Mr. Page was instructed to invite the Senators, as well as the Members of the House of Representatives from Ohio, to the luncheon.

Ohio General Assembly

H. B. 996 — This bill involving penalties for resisting an officer was brought up by a county medical society auxiliary. It was the expression of The Council that it was not sufficiently related to health and medical problems for an OSMA position.

H. B. 950 — This is a bill to establish a formula whereby the Finance Department would request boards and agencies to raise fees when revenues fall behind operation costs by 5 per cent. A position of opposition was expressed to this legislation, since it would tend to remove from the legislative branch authority for levying taxes, and transfer such authority to the executive branch. The Council affirmed the principle in connection with this bill that, even though M. D. licensees of the Ohio State Medical Board have paid a large share of the operational costs of such Board in the past, and are willing to do so

in the future, through payment of fees for examination and re-registration, The Council does affirm that the Board represents the police power of the state and its support is actually an obligation of the public which is protected.

H. B. 937 — This bill would establish an administrative secretary to serve all professional licensing boards, such secretary to have no authority in the professional and licensing operations of the board, but to act in a housekeeping role exclusively. This proposal was re-endorsed in principle.

H. B. 911 — Standard re-registration procedure does not affect medical doctors at this time. No action.

Workmen's Compensation

Mr. Campbell reported on a meeting with Jay Flowers, Administrator of the Bureau of Workmen's Compensation, at which time a representative of the Ohio Society of Pathologists, a representative of the Ohio Hospital Association, OSMA Executive Secretary and Mr. Campbell presented a request that payments for professional laboratory services be made to the physician rather than the hospital.

Redistricting Committee

Dr. Paul N. Ivins, chairman of the Committee on Redistricting, presented a progress report.

OSMA Pension Plan

The Council approved the extension of the OSMA Employees' Pension Plan, to make such plan available to county medical society employees, on request. It was the expression of the legal counsel that this extension would in no way affect the present Employees' Pension Plan, since the funds would not be co-mingled, but would permit the OSMA to render a service to county medical societies.

Professional Liability Insurance

Mr. Campbell reported on the Insurance Committee investigation provided for under Resolution No. 7, of the 1967 House of Delegates, with regard to Group Professional Liability Insurance. To date, no company has been found willing to offer a group OSMA-sponsored plan with a waiver of underwriting; that is, without risk selection. This fails to solve the problem of the physician who has had his professional liability insurance canceled.

The Council authorized the Committee on Insurance to carry out a survey in connection with the OSMAgram to determine the extent of the problem and interest in such an insurance program.

Nurse Anesthetists

Communications from Drs. William T. Washam, Carl Wasmuth and Mrs. Eleanor J. Meier, President, Ohio State Association of Nurses Anesthetists, regarding nurse anesthetists, were studied by The Council. It was the decision of The Council that the current discussion be discontinued.

Medical School Practice of Medicine

The Council reviewed the publication "datagram," Vol. 9, No. 7, dated January, 1968, published by the Association of American Medical Colleges. Such publication outlined the extent of group medical practice now being conducted by faculties of schools of medicine in the United States.

Authentic Health Information

The Council studied a letter from Dr. Carl E. Madsen, Jr., Painesville, which concerned a communication on sulfonamides, dated January 8, 1968, from the Director of the Bureau of Medicine of the Department of Health, Education, and Welfare. The Council authorized the Executive Secretary, who is a member of the Advisory Committee to the Director of the AMA Communications Division, to bring before that committee the urgency that the AMA increase its communication with the public through all media in the field of authentic health advice, rather than to let this obligation become a province of the layman and government bureaus.

AMA President

The President brought before The Council a communication from Dr. Milford O. Rouse, President of the American Medical Association, regarding a project for communication with every medical society. The Council endorsed Dr. Rouse's proposal and assured him of OSMA cooperation and participation.

Family Practice Seminar

With regard to a request for cosponsorship of a family practice seminar with the Ohio Academy of General Practice, The Council voted to give its approval to the seminar and cosponsorship without financial aid and further suggested that when such conferences are set up in the future the planning and development of the program be done by both OSMA and OAGP, preferably through the existing Joint Committee on General Practice.

Statement for Professional Services

A recommended "statement for professional services," requested by the House of Delegates and developed by the OSMA staff, was presented by Mr. Edgar. The Council accepted the proposed statement for publication and distribution under the sponsorship of the Ohio State Medical Association.

Committee Reports

Committee on Environmental and Public Health

Mr. Gillen reported on the meeting of the Committee on Environmental and Public Health, held January 24.

(Continued on Page 477)



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There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

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For fifteen years Pro-Banthine has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthine has reestablished its pharmacologic effectiveness in diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthine. The duodenum was intubated. Pro-Banthine in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

Contraindications: Glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

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Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done ... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

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up to 10-12 hours clear breathing on one tablet



Statewide Fluoridation

In approving these minutes, The Council endorsed the principle of statewide fluoridation of all public water supplies where indicated in Ohio and voted to lend its support to such a proposal.

Intoxication Tests

The committee presented a discussion regarding the medical/legal aspects in administering intoxication tests which are provided for in the Omnibus Highway Safety Act, passed by the 107th Ohio General Assembly. The Council decreed that physicians be warned by the OSMA about drawing blood for intoxication tests without informed consent of the patient, in writing, since the law provides no immunity from civil or criminal prosecution for such a procedure.

The Council further requested that an attempt to amend the law to provide for such immunity be undertaken at the next opportunity.

A memorandum prepared by OSMA legal counsel for presentation at a public hearing on the intoxication tests, conducted February 16, 1968, by the Director of Health, was approved by The Council.

The report of the Committee on Environmental and Public Health, as a whole, **was approved.**

Maternal Health

Mr. Gillen reported on the meeting of the Committee on Maternal Health, held January 27-28, 1968, at Granville, Ohio. Report **approved.**

Other Meetings

Mr. Gillen reported on the Second Ohio Conference for Medical Chiefs of Staff, in Cincinnati, January 20-21, 1968, and the Student Lectures, University of Cincinnati, February 10.

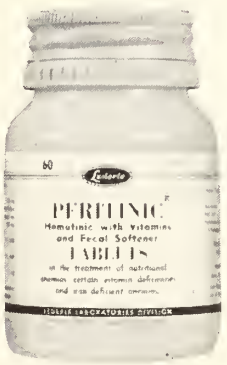
Mr. Page reported on a meeting of the AMA Council on Legislation, held January 20-21, in Chicago.

By official action, The Council voted an expression of thanks and appreciation to Past President Lawrence C. Meredith, for the many hours of artistic skill involved in woodcarving a three-foot replica of the OSMA seal which now overlooks the entranceway to the headquarters office.

The Council then adjourned after setting times and dates for the next meeting: 2:00 P. M. to 5:00 P. M., Saturday, March 30; 9:00 A. M. to 12:00 NOON, Sunday, March 31.

Attest: HART F. PAGE,
Executive Secretary.

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* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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Who's Who . . . NATIONALLY

Listed below in alphabetical order are the photographs and curriculum vitaes on 20 out-of-state speakers which will be appearing during the 1968 OSMA Annual Meeting in Cincinnati, May 13-17. Keep a close watch for the com-



EDWARD R. ANNIS, M.D.
MIAMI, FLORIDA

Past President of the American Medical Association. Appearing on "Medicare Plus Two Years – How Is the Medical Profession Faring?" General Session.



WALTER C. STOLOV, M.D.
SEATTLE, WASHINGTON

Associate Professor, Department of Physical Medicine and Rehabilitation, University of Washington. Appearing on Physical Medicine and Rehabilitation program.





REV. DR. PAUL B. McCLEAVE
CHICAGO, ILLINOIS

Director, Department of Medicine and Religion, American Medical Association. Appearing on "The Pill" panel General Session.



JACK L. PULEC, M.D.
ROCHESTER, MINNESOTA

Practice Otologic and Neuro-otologic Surgery at the Mayo Clinic, Associate Professor of Otolaryngology and Rhinology in the Mayo Graduate School of Medicine. Appearing on the E.N.T. Program.



PAUL F. WEHRLE, M.D.
LOS ANGELES, CALIFORNIA

Chief Physician, Children's Division, Los Angeles County General Hospital. Appearing on Health Commissioners Program.



FRANK J. AYD, JR., M.D.
BALTIMORE, MARYLAND

Diplomate in Psychiatry. Internationally known lecturer, writer, and psychiatrist. He is editor and publisher of the Medical-Moral Newsletter and the International Drug Therapy Newsletter. Appearing on "The Pill" panel General Session.



MAX S. SADOVE, M.D.
CHICAGO, ILLINOIS

University of Illinois Anesthesiology, Head, Department of Research and Educational Hospitals. Appearing on Anesthesiologists and Chest Physicians Program.



HARRY SHWACHMAN, M.D.
BOSTON, MASSACHUSETTS

Clinical Professor of Pediatrics at the Children's Hospital Medical Center, Harvard Medical School. Chairman of the Education Committee of the National Cystic Fibrosis Research Foundation. Appearing on Pediatrics Program.



JOHN C. GAISFORD, M.D.
PITTSBURGH, PA.

Director of the Departments of Plastic And Reconstructive Surgery, Allegheny General Hospital and the Western Pennsylvania Hospital. Clinical Assistant Professor of Surgery, University of Pittsburgh School of Medicine. Appearing on the Plastic Surgery Section Program – General Session.



OLIVER FIELD, LLB.
CHICAGO, ILLINOIS

Department of Investigation, American Medical Association. Appearing on "Medical Hooey" General Session.



SAMUEL BELLET, M.D.
PHILADELPHIA, PA.

Director, Division of Cardiology at the Philadelphia General Hospital. Member of the President's Commission on Cancer, Heart Disease and Stroke. Appearing on Occupational Medicine Program.

KNOWN SPEAKERS

plete Official Program which will be mailed to each member of the Ohio State Medical Association around April 15. Be certain to check your program for the exact time and place of each presentation you plan to attend.

EDWARD T. TYLER, M.D.
LOS ANGELES, CALIF.

Clinical Professor of Medicine and Obstetrics and Gynecology, UCLA School of Medicine; Medical Director, Family Planning Centers of Greater Los Angeles. Appearing on "The Pill" panel General Session.



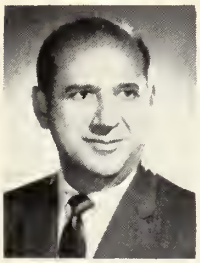
LAURENCE P. SKENDZEL, M.D.
TRAVERSE CITY, MICHIGAN

Pathologist at Munson Medical Center; Secretary of the Standards Committee of the College of American Pathologists. Appearing on the Conference on Laboratory Medicine.

Senior Ophthalmic Surgeon to the Royal Victoris Eye and Ear Hospital, Dublin. Honorary member of the Society of British Neurological Surgeons Appearing on Ophthalmology program.



DR. ALAN J. MOONEY
DUBLIN, IRELAND



FRANK VELLIOS, M.D.
INDIANAPOLIS, INDIANA

Professor and Chairman of Pathology, Indiana University School of Medicine. Appearing on Pathology program.



E. CUYLER HAMMOND, SC.D.
NEW YORK, N.Y.

Vice President for Epidemiology and Statistics, American Cancer Society. Appearing on "Tenth Annual Cancer Conference" General Session.



JOHN W. GREENE, JR., M.D.
LEXINGTON, KENTUCKY

Chairman, Department of Obstetrics and Gynecology, University of Kentucky Appearing on Obstetrics and Gynecology program.



GEORGE J. GARCEAU, M.D.
INDIANAPOLIS, INDIANA

Distinguished Professor Emeritus of Orthopaedic Surgery, Indiana University School of Medicine; Past President of the American Board of Orthopaedic Surgery. Appearing on Orthopaedic program.

20 OUT-OF-STATE SPEAKERS WHICH WILL BE APPEARING DURING THE 1968 OSMA ANNUAL MEETING





WILLIAM H. GORDON, M.D.
LUBBOCK, TEXAS

Fellow of Cardiovascular Diseases, Massachusetts General Hospital (Harvard); Certified American Board of Internal Medicine. Appearing on "Medical Hooey" General Session.



JAMES B. GILLESPIE, M.D.
EVANSTON, ILLINOIS

Secretary for Chapters, American Academy of Pediatrics. Appearing on Pediatrics program.

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WEDNESDAY, MAY 15, 1968

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Enclosed is $_____ to pay for:

_____Tickets to Gaslight Party ($8.00 per person)

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Wednesday, May 15
Netherland Hilton Hotel
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Featuring Chicago's
GASLIGHT ROADSHOW

Thursday, May 16
Cincinnati-Exposition Center
11:30 A.M.
Featuring Congressman
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Please make checks payable to: **THE OHIO STATE MEDICAL ASSOCIATION**

Fun!

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GENERAL SESSION

Tenth Annual Cancer Conference presented by The Ohio Division Inc., American Cancer Society

WEDNESDAY, MAY 15

9:00 A.M.

Room 209, Cincinnati-Exposition Center

The Participants

Joseph A. Bonta, M.D., Columbus, President, American Cancer Society, Ohio Division, Inc.

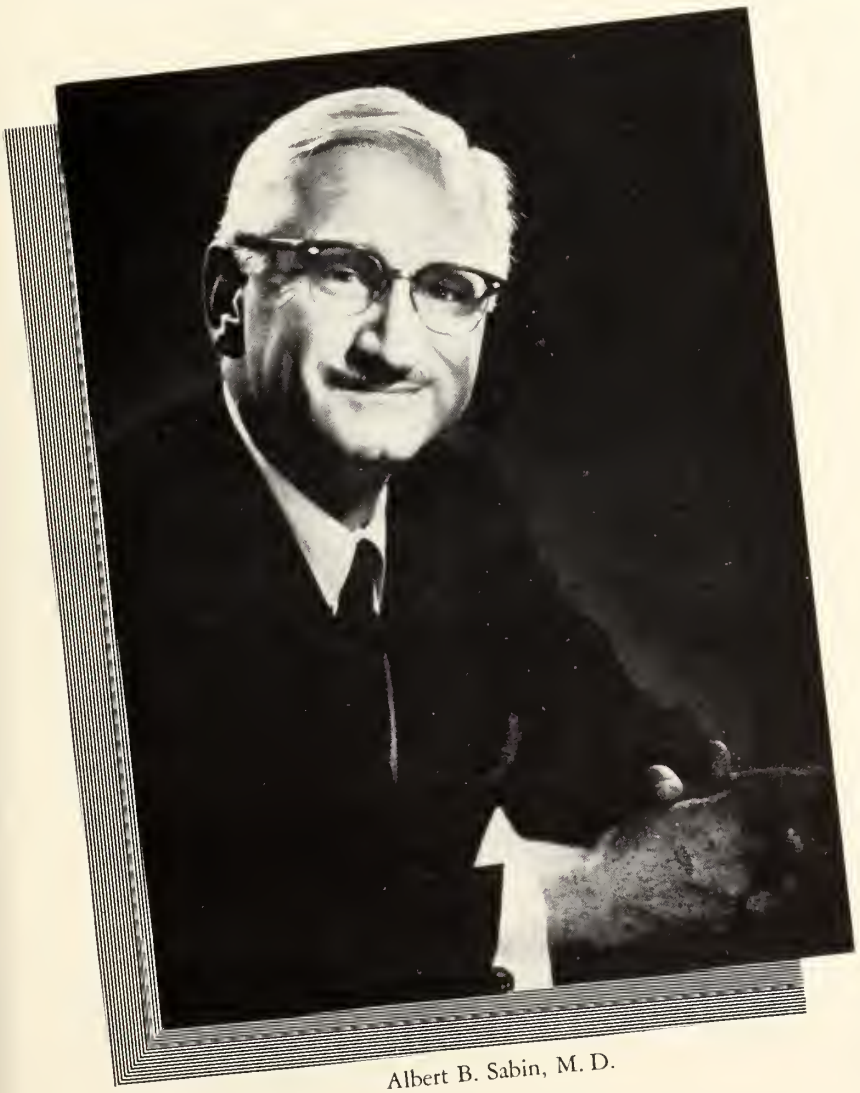
William F. Boukalik, M.D., Cleveland, Vice President, American Cancer Society, Ohio Division, Inc.

E. Cuyler Hammond, Sc.D., New York, New York, Vice President for Epidemiology and Statistics, American Cancer Society.

Robert E. Howard, M.D., Cincinnati, President, The Ohio State Medical Association.

John Peter Minton, M.D., Columbus, Administrative Chief Resident, Department of Surgery, The Ohio State University Hospital.

Albert B. Sabin, M.D., Cincinnati, The Children's Hospital Research Foundation.



Albert B. Sabin, M. D.

The Program

Presiding: Dr. Boukalik

Welcome by Dr. Robert E. Howard and Dr. Joseph A. Bonta

Panel Discussion

Moderator: Dr. Boukalik

9:10 Present Status of the Search for a Possible Role of Viruses in Human Cancer — Dr. Sabin

Cancer Immunology — Dr. Minton

Cancer Prevention — Dr. Hammond

10:10 A.M. Question and Answer Period

10:30 A.M. Adjournment

GENERAL SESSION

WEDNESDAY, MAY 15
1:30 P.M.

ROOM NO. 209

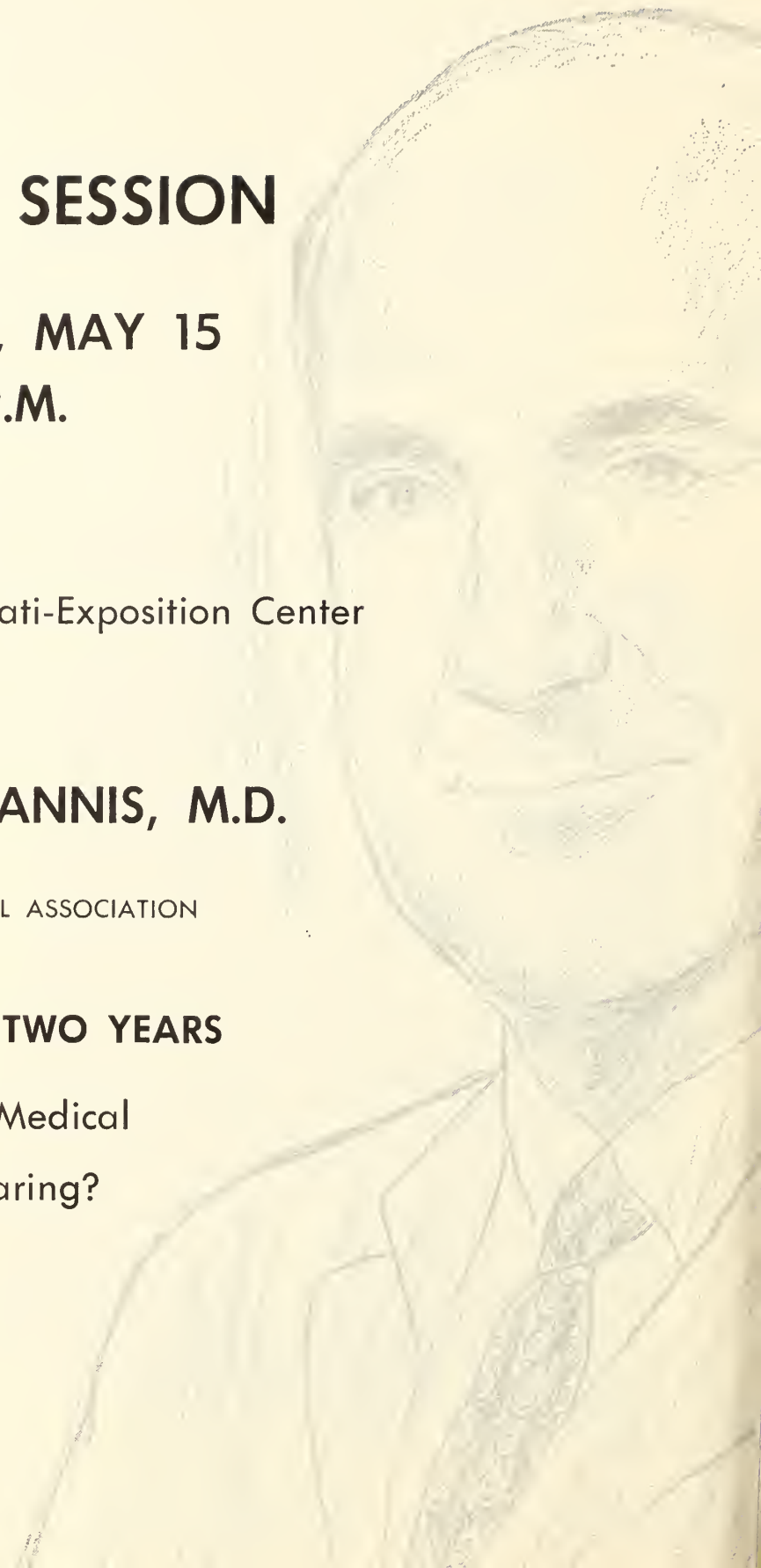
Cincinnati-Exposition Center

Featuring

EDWARD R. ANNIS, M.D.

PAST PRESIDENT,

AMERICAN MEDICAL ASSOCIATION



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FOR THE

1968 OSMA ANNUAL MEETING

Cincinnati May 13-17

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"You CAN Teach an Old Dog New Tricks"

CONFERENCE ON LABORATORY MEDICINE

FRIDAY, MAY 17

9:00 A.M.

Room 211, Cincinnati-Exposition Center

Program sponsored by the OSMA Committee on Laboratory Medicine.

The Participants

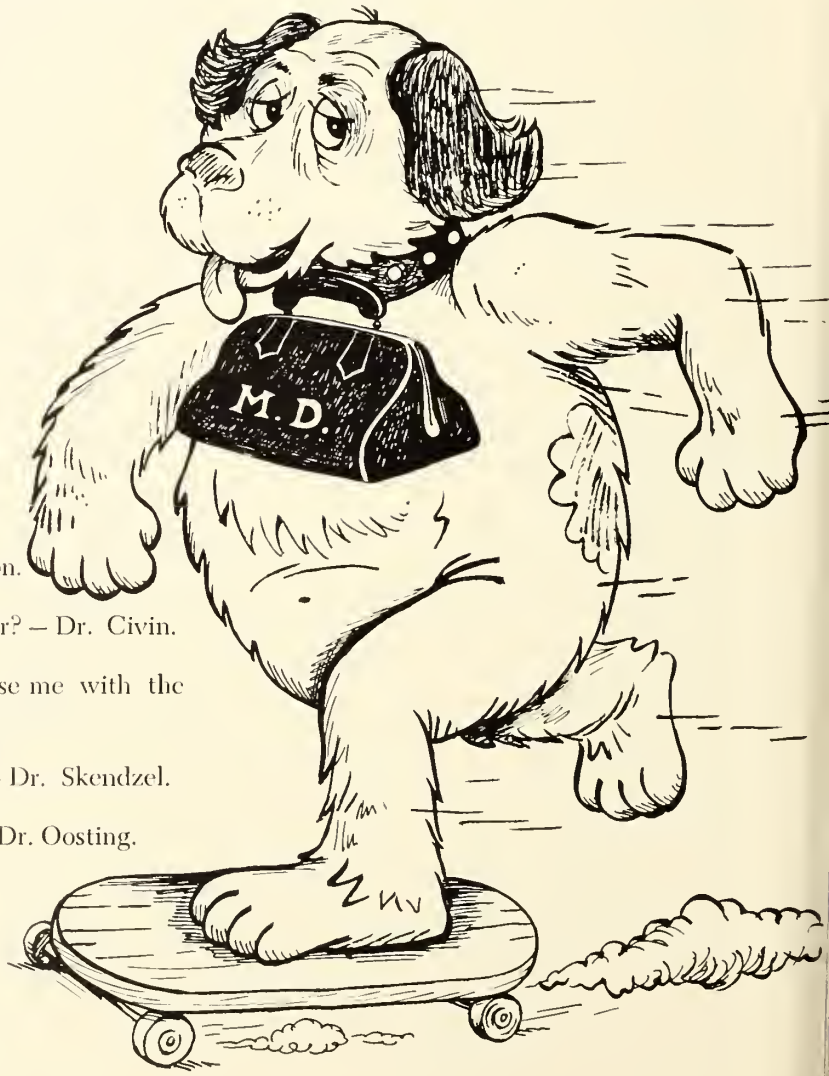
Hal Civin (W. Harold), M.D., Cincinnati, University of Cincinnati College of Medicine, Professor and Chairman Dept. of Laboratory Medicine, Cincinnati General Hospital.

Daniel J. Hanson, M.D., Toledo, Member, OSMA Committee on Laboratory Medicine.

George C. Hoffman, M.D., Cleveland, Dept. of Clinical Pathology, Cleveland Clinic.

Melvin Oosting, M.D., Dayton, Dir., Diagnostic Laboratories, Miami Valley Hospital, Chairman, Committee on Laboratory Medicine.

Laurence P. Skendzel, M.D., Traverse City, Michigan, Pathologist at Munson Medical Center; Secretary of the Standards Committee of the College of American Pathologists.



Panel Program

Moderator: Dr. Oosting

9:00 Control Out of Chaos —Dr. Hanson.

9:15 What Do You Want That Test For? — Dr. Civin.

9:30 I've Got a Number — Don't Confuse me with the Facts — Dr. Hoffman.

9:45 Quality Control — Who Needs It! — Dr. Skendzel.

10:00 Where Do We Go From Here? — Dr. Oosting.

Watch for These Exhibits at The OSMA Annual Meeting

New Cincinnati-Exposition Center, May 13 - 17

ONE OF THE OUTSTANDING FEATURES of the OSMA Annual Meeting will be presentation of exhibits in the Cincinnati-Exposition Center in downtown Cincinnati. The display on the exhibit floor of the Center will include 41 Scientific Exhibits, 25 Health Education Exhibits, and 103 Technical Exhibits. All those who attend the Annual Meeting are urged to take advantage of this opportunity to view the exhibits and chat with their sponsors.

For the convenience of those attending, most of the programs are coordinated to break at a given time in the morning, and again in the afternoon. This arrangement affords time to view exhibits without missing favorite scientific sessions.

For convenience in checking locations, the exhibitors are arranged according to booth numbers. Exhibits will open for viewing at NOON on Tuesday, May 14, and will close at 1:00 P. M. on Friday, May 17. Actual exhibit hours are as follows:

Tuesday, May 14	12:00 Noon to 4:30 P. M.
Wednesday, May 15	9:00 A. M. - 4:00 P. M.
Thursday, May 16	9:00 A. M. - 4:00 P. M.
Friday, May 17	9:00 A. M. - 1:00 P. M.

Scientific Exhibits

Booth No.	
S-109	Anterior Segment Eye Diseases Ira A. Abrahamson, Jr., M. D. Ira A. Abrahamson, Sr., M. D.
S-110	Preservation of Laryngeal Function in Head and Neck Cancer Surgery Donald A. Shumrick, M. D.
S-111	Five Common Facial Fractures Alvin C. Poweleit, M. D. Robert C. Kratz, M. D.
S-112	Minor Surgical Correction of the Cicatricial Alopecias D. Bluford Stough, III, M. D.
S-113	Spasmodic Torticollis — Results after Cervical Rhizotomy in 75 Cases Wallace B. Hamby, M. D. Stanton Schiffer, M. D.
S-114	Revision of Facial Scars H. William Porterfield, M. D. John L. Terry, M. D. John C. Trabue, M. D.
S-115	Leg Ulcers — Differential Diagnosis and Treatment Henry H. Roenigk, Jr., M. D. Jess R. Young, M. D.
S-116	Dry Ice Refrigeration for Septic Gangrene J. C. Rosenberg, M. D., Ph. D. J. F. Gorman, M. D. S. A. Hussain, M. D.
S-117	Post Phlebitic Disease E. A. Husni, M. D.
S-118	Tri-Malleolar Fractures A. L. Sparks, M. D. E. E. Bauman, M. D.
S-119	Support of the Failing Circulation — Clinical Application John H. Kennedy, M. D. Otto Haiderer, M. D.
S-120	Mitral and Aortic Valve Replacement With A Caged Lens Prosthesis Frederick S. Cross, M. D. Motoichi Akao, M. D. Richard D. Jones, Ph. D.
S-121	Experience in a Large Cardiac Monitoring Unit E. Gordon Margolin, M. D. Richard Charles, M. D. Vijay Sanghvi, M. D.

(Continued on Next Page)

SCIENTIFIC EXHIBITS *(Cont'd.)*

Booth No.

S-122 The Effect of Hyperbaric Oxygen on Anaerobic and Aerobic Infections
G. B. Stansell, M. D.
R. M. Glad, M. D.

S-123 Acute and Chronic Lesions from Antibiotic Injection
Daniel J. Hanson, M. D.

S-124 Ventriculo-Atrial Shunt for Dementia
James H. Salmon, M. D.
Otto Appenzeller, M. D.

S-125 Percutaneous Cordotomy for Pain Relief
James H. Salmon, M. D.

S-126 Diagnosis of Esophageal Disease Utilizing the Millhon Battelle Esophageal Probe
William A. Millhon, M. D.
Phillip Jarvis, M. D.
Donald E. Hoffman, M. D.
C. Joseph Cross, M. D.
Judson S. Millhon, M. D.

S-127 Esophageal Atresia
Lester W. Martin, M. D.
William R. Richardson, M. D.
Darryl Sutorius, M. D.

S-128 The Esophagus
Constantine D. Morros, M. D.

S-129 Bilateral Bullous Emphysema
John Storer, M. D.
M. P. Thomas, M. D.
A. Grierson, M. D.

S-130 Physiologic Voiding Test In Children
Walter A. Keitzer, M. D.
Birendra Tandon, M. D.
James Allen, M. D.
Edward Bernreuter, M. D.
Mark Harrold, M. D.

S-131 Urinary Diversion: A Comparison of Methods
Gerald Stark, M. D.
Paul D. Carter, M. D.
Giuseppe Corcione, M. D.

S-132 Renal Transplantation in Children
Luis L. Gonzalez, M. D.
Lester Martin, M. D.
Clark West, M. D.
William Fullen, M. D.

S-133 Teaching Urinalysis
Arthur T. Evans, M. D.
Robert Helmling, M. D.

S-134 Lymphangiectasis of the Penis
Victor C. Laughlin, M. D.
Arturo Basa, M. D.

Booth No.

S-135 Carcinoma of the Bladder
Paul K. Danner, M. D.

S-136 Blood Cytology in Cancer
Thomas D. Stevenson, M. D.
Joan C. Mattson, M. D.
Emmerich von Haam, M. D.

S-137 Dose Reduction and Radiopharmaceutical Dosimetry in Pediatric Nuclear Medicine
James G. Kereiakes, Ph. D.
Henry N. Wellman, M. D.
Eugene L. Saenger, M. D.
Vince Sodd, Ph. D.
Gustave K. Bahr, Ph. D.
Ben I. Friedman, M. D.
James Mack, M. D.
Byron Branson, M. S.

S-138 The Laser in Cancer Research
Leon Goldman, M. D.
J. R. Rockwell, Jr., M. Sc.
Edmond Ritter, Ph. D.
V. E. Siler, M. D.
Donald Blaney, M. D.
James Fidler, M. D.
Robert Meyer
Robert Otten
K. W. Kitzmiller, M. D.

S-139 Chromosome Analysis in Medical Practice
John D. Blair, M. D.
Carolyn A. Leonard, B. A.

S-140 Endometrioid Carcinoma of the Ovary
Abdul F. Naji, M. D.

S-141 A Phototesting Center — Development — Goals — Results
Robert M. Glasgow, M. D.
Jack Baldwin, M. D.

S-142 Occupational Acro-osteolysis — A Worldwide Problem
Harold Schneider, M. D.
Evelyn Hess, M. D.
George Roush, M. D.

S-143 Acro-Osteolysis, A New Occupational Bone Disease
Carroll F. Tatum, M. D.
Rex H. Wilson, M. D.
William S. McCormick, M. S.

S-144 Skeletal X-ray Findings in Congenital and Juvenile Hypothyroidism
Harold Schneider, M. D.
David Eversole, M. D.
Frederic Silverman, M. D.

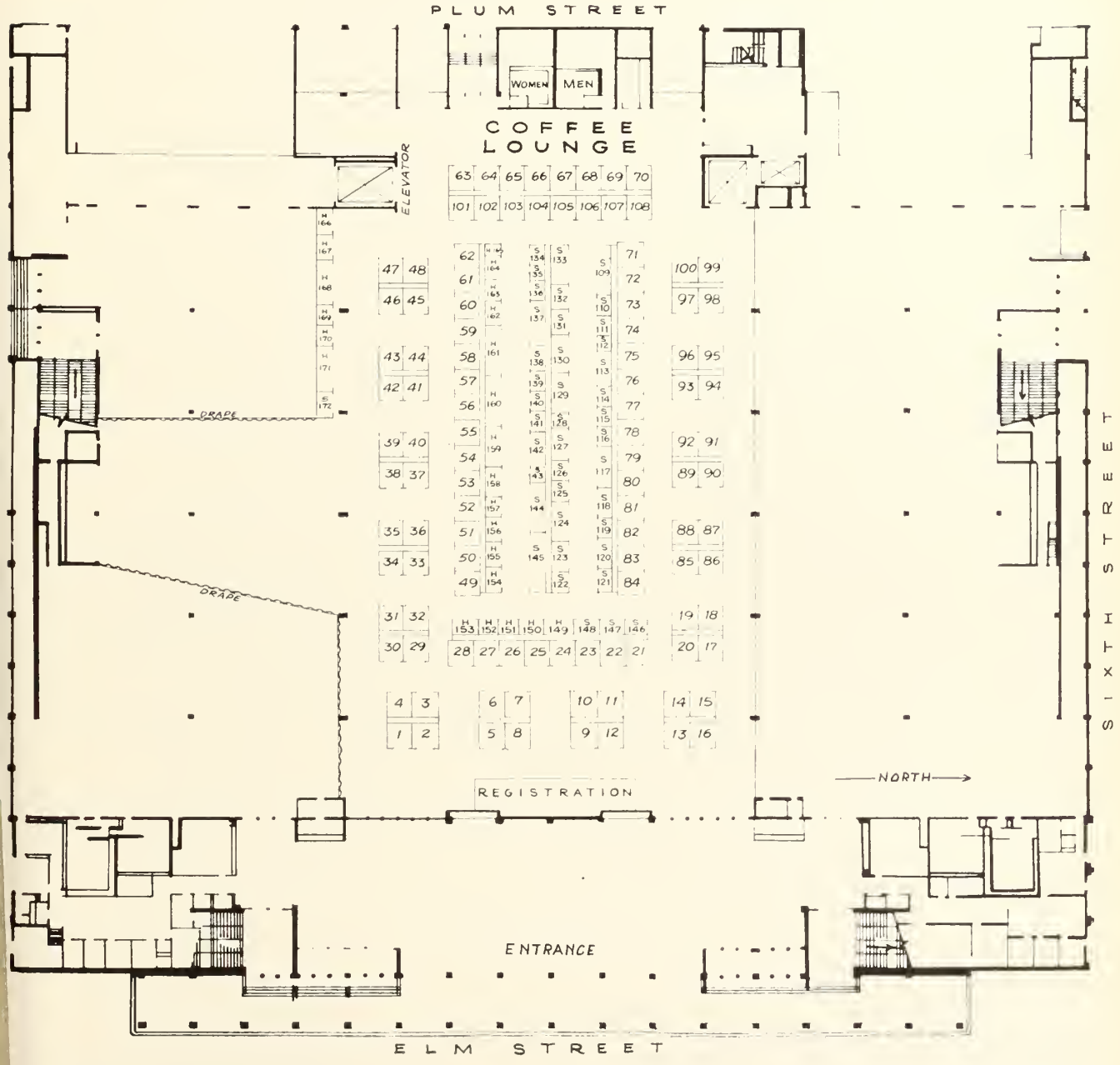
(Roster Continued on Page 488)

Cincinnati—Exposition Center

A Key to Roster of Exhibits on Accompanying Pages

Booths 1 to 108	Technical Exhibits
Booths S-109 to S-148 and S-172	Scientific Exhibits
Booths H-149 to H-171	Health Education Exhibits

(Booths 98, 101, and 102 Converted to Health Education Exhibits)



Morning, Noon, and Afternoon Breaks in the Program Will Give Ample Time for Frequent Visits to the Exhibit Floor

Scientific Exhibits *(Cont'd.)*

Booth No.	
S-145	Surgical Aspects of Intersex William R. Richardson, M. D. Lester W. Martin, M. D.
S-146	A Perinatal Unit — A New Concept in Obstetrical Research Maternal and Fetal Health Care Jacques Roux, M. D., Peter Adam, M. D. Maximino Alcancia, M. D., Reinhart Billiar, M. D., Frank Critchfield, M. D., August Hensons, B. S., M. Jassani, M. D., Katherine King, M. D., Margaret Knappenberger, B. S., Rosemary Lemr, R. N., T. J. Lin, M. D., M. Lindheimer, M. D., Brian Little, M. D., Michael R. Neuman, Ph. D., R. Schwartz M. D., A. Sweet, M. D., and Peter Weston, M. D.
S-147	Rheumatoid Arthritis of the Hand and Wrist, Early Roentgen Findings and Technique Aaron S. Weinstein, M. D. Richard L. Clark
S-148	The Laboratory Diagnosis of Rheumatic Disease E. V. Hess, M. D. M. J. Heimbrock, M. S.
S-172	Corneal Transplants Abbot G. Spaulding, M. D.

Health Education Exhibits

Booth No.	
H-98	Highway Safety featuring "Alcohol in Relation to Highway Safety" and "Emergency Medical Services" Ohio Department of Health
H-101 and 102	Evolution in Seat Belt Protection Injury Control Program, U.S.P.H.S. —NCUIH, Cincinnati
H-149	Hospitalization of the Mentally Ill in Ohio Ohio State Medical Association's Committee on Mental Health
H-150	Physicians' Placement Service, OSMA and AMA
H-151	Committee on Maternal Health Ohio State Medical Association's Committee on Maternal Health
H-152	The Autopsy in a Community Hospital A. Raftery, M. D. Huseyin Sarikaya, M. D.
H-153	Know Your Vitamins Therese Mondeika
H-154	Families in Crisis F. A. Lingl, M. D. E. N. Hinko, M. D.
H-155	Ohio State Society of Medical Assistants Professional organization of personnel employed by qualified Doctors of Medicine.
H-156	C & I Club, Inc. United Ostomy Association, Inc., Los Angeles, California
H-157	Smoking and Health Ohio Education Program on Smoking and Health
H-158	Emergency Health Preparedness Ohio Department of Health
H-159	Ohio Comprehensive Statewide Planning for Vocational Rehabilitation Governor's Council on Vocational Rehabilitation; Bureau of Vocational Rehabilitation
H-160	Woman's Auxiliary to the Ohio State Medical Association
H-161	A Method of Teaching Using a Portable Slide Viewer Harold Schneider, M. D. Edward Gall, M. D.
H-162	The Coroner in the Community Frank P. Cleveland, M. D., Hamilton County Coroner S. Adriano, M. D., Chief Deputy Coroner B. Yamaguchi, M. D., K. Alamin, M. D., H. W. Neumann, M. D., G. Meyers, M. D., Deputy Coroners

Health Education Exhibits *(Cont'd.)*

Booth No.	
H-163	Medical Libraries; Your Prime Source of Up-to-date Information Libraries, College of Medicine: OSU, Case-Western Reserve University, Medical College of Ohio at Toledo, and University of Cincinnati
H-164	The Ohio State Regional Medical Program Neil C. Andrews, M. D., Coordinator
H-165	Chemoprophylaxis Reduces TB Morbidity Ohio Thoracic Society; Ohio Tuberculosis & Health Association
H-166	Progress Report: Regional Medical Programs Ohio State Regional Medical Program Neil C. Andrews, M. D., Coordinator
H-167	American Association of Industrial Nurses Ohio Association of Industrial Nurses Southwestern Ohio Association of Industrial Nurses
H-168	Cancer and Smoking Health Exhibit American Cancer Society, Cincinnati-Hamilton County Unit
H-169	The Aesculapian Staff and the Caduceus as Medical Symbols Victor C. Laughlin, M. D. Arturo Basa, M. D.
H-170	Nutrition Nonsense American Medical Association
H-171	Childhood Cancer American Cancer Society, Ohio Division, Inc.

Technical Exhibits

Booth No.	Company and City
1-2	Crocker-Fels Company, Cincinnati.
3	3M Business Products, Cincinnati
4	Flint Laboratories Division of Travenol Laboratories, Inc., Morton Grove, Ill.
5	Burroughs Wellcome & Co. (USA) Inc., Tuckahoe, N. Y.
6	New York Life Insurance Co., Columbus and Cincinnati
7	Parke, Davis & Company, Detroit, Mich.
8	Eli Lilly and Company, Indianapolis, Ind.
9	W. B. Saunders Company, Philadelphia
10	Merck Sharp & Dohme, West Point, Pa.
11	Pfizer Laboratories, New York
12	Lederle Laboratories, Pearl River, N. Y.
13	E. R. Squibb & Sons, New York
14	Imperial Fashions, Div. of British House, Los Angeles, Calif.
15	Organon, Inc., West Orange, N. J.
16	G. D. Searle & Co., Chicago
17	J. B. Lippincott Company, Philadelphia
18	Cincinnati & Suburban Bell Telephone Company, Cincinnati
19	USV Pharmaceutical Corp., New York
20	Schering Corporation, Union, N. J.
21-22	Hoechst Pharmaceutical Co., Div. of American Hoechst Corp., Cincinnati
23	Turner and Shepard, Inc., Columbus
24-25	The Procter & Gamble Co., Cincinnati
26-27	The Max Wocher & Son Co., Cincinnati
28	Sandoz Pharmaceuticals, Hanover, N. J.
29	Mead Johnson Laboratories, Evansville, Indiana
30	S. H. Camp & Company, Jackson, Mich.
31	Nationwide Insurance, Columbus
32	Geigy Pharmaceuticals, Ardsley, N. Y.
33	The Wm. S. Merrell Company, Cincinnati
34	Pepsi Cola Bottling Company, Cincinnati
35	Systemedics, Inc., Princeton, N. J.
36	Clayton L. Scroggins Associates, Cincinnati
37	Philips Roxane Laboratories, Columbus
38	Berkeley Medical Instruments, Berkeley, Calif.
39	Jones Insurance Co., Cincinnati
40	7-Up Bottling Co., Cincinnati
41	Wm. P. Poythress & Co., Inc., Richmond, Virginia
42	North American Pharmacal Co., Dearborn, Mich.
43	Massachusetts Indemnity & Life Insurance Co., Cincinnati
44	Key Pharmaceuticals, Inc., Miami, Florida
45	Medco Products Co., Inc., Tulsa, Okla.
46	H. P. Gardner Co., Columbus
47	Ross Laboratories, Columbus

(Continued on Next Page)

TECHNICAL EXHIBITS *(Cont'd.)*

Booth No.	Company and City
48	Tasco Products, Dayton
49	Smith Kline & French Laboratories, Philadelphia
50	Carnation Company, Los Angeles
51	PRO Services, Inc., Philadelphia
52	Hewlett-Packard Co., Skokie, Illinois
53	Breon Laboratories, Inc., New York
54	Janrus Recorders Corp., New York
55	Professional Administrative Service, Cincinnati
56	General Electric Company X-Ray Dept., Indianapolis, Ind.
57	Professional Office Buildings, Inc., Madison, Wisconsin
58	International Business Machines, Cincinnati
59	Ohio Medical Indemnity Inc., Columbus
60	National Institute for Better Reading, Inc., Bellmore, N. Y.
61	Tice & Co. Inc., Columbus
62	Warren-Teed Pharmaceuticals Inc., Columbus
63	Ciba Pharmaceutical Company, Summit, New Jersey
64	Endo Laboratories Inc., Garden City, New York
65	The Medical Protective Company, Fort Wayne, Ind.
66	Barry Laboratories Inc., Detroit, Mich.
67	Wm. A. Rudd, Inc., Cincinnati
68	Ayerst Laboratories, New York
69	Ortho Pharmaceutical Corp., Raritan, N. J.
70	Audio Digest Foundation, Los Angeles
71	Winthrop Laboratories, New York
72-73	Contour Chairs of Columbus, Inc., Columbus
74	William H. Rorer, Inc., Ft. Washington, Pennsylvania
75	Scudder, Stevens & Clark, Cincinnati
76	Physicians Planning Corporation, Cincinnati
77	Roche Laboratories, Nutley, N. J.
78	Medical-Dental-Hospital Bureau of Cincinnati, Cincinnati
79	Loma Linda Foods, Riverside, California
80	The Dow Chemical Company, Midland, Michigan
81	Astra Pharmaceutical Products, Inc., Worcester, Mass.
82	Beecham Research Laboratories, New York
83	Arnar-Stone Laboratories, Inc., Mt. Prospect, Illinois
84	Gerber Products Company, Fremont, Michigan
85	Abbott Laboratories, North Chicago, Ill.
86	Medical Economics Consultants, Inc., Dayton
87	Dictaphone Company, Cincinnati
88	Siemens Medical of America Inc., Addison, Illinois
89	The Coca-Cola Company, Atlanta, Ga.
90	America Rents, Inc., Cincinnati
92	Stiefel, Oak Hill, New York
93	Daniels-Head & Associates, Inc., Portsmouth
95	Ormont Drug Co., Inc., Englewood, N. J.
96	Royal Brown Bottling Co., Cincinnati
97	Wallace Pharmaceuticals, Cranbury, New Jersey
99	A. Bruce Crock, Inc., Cincinnati
100	Robert L. Rupp & Associates, Columbus
103	Denison Mattress Factory, Denison, Texas
104-105	American Financial Corp., Cincinnati
106	Bristol Laboratories, Cincinnati
107	EMKO Company, St. Louis, Mo.
108	Ives Laboratories, Inc., New York

Resolutions Submitted for Consideration At the 1968 Annual Meeting

HERE ARE THE TEXTS of resolutions which will be presented for consideration of the House of Delegates at the 1968 Annual Meeting of the Ohio State Medical Association, May 13-17, in Cincinnati. These resolutions were received at the Columbus Office on or before March 14, thereby meeting the 60-day deadline. No resolution which failed to meet the 60-day deadline may be introduced unless the sponsor secures at least two-thirds consent vote of the delegates present at the meeting.

Copies of all resolutions presented to the Columbus Office are being sent to the individual Delegates and Alternate Delegates so that they may discuss them with their county medical societies, if they care to do so.

A resolution to be considered by the House of Delegates must be typed in triplicate; introduced by a delegate or his duly accredited alternate seated in his place; and introduced at the first session of the House of Delegates. This procedure must be followed even though the resolution may have been published in *The Journal* or sent in writing to all delegates prior to the meeting.

RESOLUTION NO. 1
Ohio Medical Indemnity, Inc.
(By the Council of the Mahoning County Medical Society)

(Text of this resolution included in packet for members of the House of Delegates.)

RESOLUTION NO. 2
AAPS Essay Contest
(By the Columbus Academy of Medicine)

RESOLVED, That the Ohio State Medical Association endorse the Essay Contest of the Association of American Physicians and Surgeons with the choice of titles: (1) The Advantage of Private Medical Care, or (2) The Advantages of the American Free Enterprise System.

RESOLUTION NO. 3
Usual and Customary Fee, Ohio Welfare Department
(By the Erie County Medical Society)

(Text of this resolution included in packet for members of the House of Delegates.)

RESOLUTION NO. 4
Amendment to OSMA Constitution and Bylaws Regarding Citizenship of Members
(By the Lorain County Medical Society)

WHEREAS, County medical societies, as components of the Ohio State Medical Association, are required to have their Constitutions and Bylaws approved by The Council of Ohio State Medical Association, and

WHEREAS, Such Constitutions and Bylaws of county medical societies basically follow the concepts contained in the Constitution and Bylaws of Ohio State Medical Association, and

WHEREAS, Citizenship is a requirement of the State Medical Board of Ohio for licensure in Ohio, except in certain cases where full citizenship requirement is waived, and

WHEREAS, The State Medical Board does not require applicants to report when they have acquired citizenship status, if endorsement was originally given under Declaration of Intention status, which is reviewed at time of licensure, and

WHEREAS, It is the opinion of members of Lorain County Medical Society that those who receive the same professional and other benefits under "Declaration of Intention" status, as natural-born Americans, should be willing to assume the full responsibilities of bona-fide citizens as soon as our laws and regulations allow. THEREFORE, BE IT

RESOLVED, That the Constitution and Bylaws of Ohio State Medical Association be amended to require that:

(1) An ASSOCIATE or equivalent member in a component medical society shall be acceptable for membership in Ohio State Medical Association, provided that:

(a) He is a bona fide Citizen of the United States, OR

(b) He must have resided in the United States for at least one (1) year, and must have filed in an appropriate court of record a declaration of his intention to become a citizen of the United States, which declaration has not been withdrawn. The period of status (b) shall not exceed five (5) years. AND

(c) He must be licensed to practice medicine and surgery by the licensing authority of the State of Ohio.

(2) An ACTIVE or equivalent member in a component medical society shall be acceptable for membership in Ohio State Medical Association, provided that:

(a) He is a bona fide citizen of the United States, AND

(b) He must be licensed to practice medicine and surgery by the licensing authority of the State of Ohio.

RESOLUTION NO. 5
Registration Fee for Nonmembers Attending OSMA Annual Meeting
(By the Trumbull County Medical Society)

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association endorse the suggestion that a registration fee of $5.00 be charged for nonmembers attending the annual OSMA meeting, with the exception of interns, residents, and medical students.

RESOLUTION NO. 6
Composition of AMA Council on Medical Education
(By the Mahoning County Medical Society)

WHEREAS, Residency training programs are conducted by the staff members of the individual hospitals concerned, and

WHEREAS, All are interested in maintaining residency training programs at the highest possible level, whether in university or nonuniversity affiliated hospitals, and

WHEREAS, A nonuniversity affiliated hospital can provide a clinical program as successfully as a university hospital, and

WHEREAS, The composition of the Council on Medical Education of the American Medical Association comprises a membership consisting heavily of medical school faculty or former faculty providing thus for a situation which can possibly discriminate against nonuniversity affiliated hospitals, NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association, through its delegates to the American Medical Association, recommend to the American Medical Association, that, as soon as possible, a change in composition of the American Medical Association Council on Medical Education be instituted to assure more equal representation on the Council by physicians practicing in nonuniversity affiliated hospitals in order to emphasize the teaching of clinical medicine.

RESOLUTION NO. 7

Proposed Changes in Ohio's Abortion Laws

(By the Academy of Medicine of Cleveland)

WHEREAS, The House of Delegates of the American Medical Association at its June 1967 meeting stated that:

> "It is to be considered consistent with the principles of ethics of the AMA for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion.", and

WHEREAS, It is probable that new legislation concerning the performance of abortions will be presented to the 1969 session of the Ohio State Legislature, and

WHEREAS, The issue of the indications for therapeutic abortion is a controversial one, with divergence of opinion within the medical profession, and

WHEREAS, The legislators are entitled to a clear, dispassionate, and objective discussion of the issues, and an accurate appraisal of the opinions of all segments of the medical profession in the State of Ohio, THEREFORE, BE IT

RESOLVED, That arrangements be made for the publishing in *The Ohio State Medical Journal* a series of articles setting forth both proponent and contrary opinions of the several facets of the issue, AND BE IT FURTHER

RESOLVED, That following the publication of the articles the members of Ohio State Medical Association be polled to ascertain their opinions concerning revisions in the present state law. The information derived from such a study should then be made known to the legislators considering the issue.

RESOLUTION NO. 8

Insurance for High School Athletes

(By the Madison County Medical Society)

WHEREAS, Ohio secondary and high schools have huge athletic programs in which the athletes are covered by insurance programs that range from excellent to none at all, and

WHEREAS, Ohio Medical Indemnity, Inc. (the doctor's plan) has a liaison with the Ohio State Medical Association that could legally, morally, and financially cover any existing voids and/or inequities, and

WHEREAS, This cover could improve the medical rapport between the medical profession and the general public interested in protecting our young athletes; NOW, THEREFORE, BE IT

RESOLVED, That the Insurance Committee of the Ohio State Medical Association formulate a plan to promote an insurance plan covering the voids that exist insurance-wise for our student athletes.

RESOLUTION NO. 9

Internship Requirement for Physician Licensure in Ohio

(By the Madison County Medical Society)

WHEREAS, An approved rotating internship has traditionally been a prerequisite for staff privileges at accredited hospitals, and

WHEREAS, Some physicians are being granted residencies in specialty training immediately upon graduation from medical school at the time of this writing; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association effect a ruling at the earliest possible moment that no physician be licensed to practice medicine in "the State of Ohio" without serving at least one year of rotating internship at an accredited hospital.

RESOLUTION NO. 10

Proposed Amendment to Medicare Law

(By the Huron County Medical Society)

WHEREAS, It is unreasonable and economically unsound to propose that the attainment of a specific age automatically implies the need for financial medical assistance; THEREFORE, BE IT

RESOLVED, That the present Medicare Law be amended to supply financial medical assistance only to those citizens proven to be in need; and that the Ohio State Medical Association petition the American Medical Association to propose to stress the above realities to the Congress of the United States and to petition it for the desirable and necessary changes in the Medicare Law.

RESOLUTION NO. 11

Internships and Residencies in Approved Hospitals for Osteopathic Physicians

(By the Huron County Medical Society)

WHEREAS, Osteopathic physicians are approaching a comparable level of medical training and education as medical doctors; THEREFORE, BE IT

RESOLVED, That all osteopathic doctors graduating from recognized, approved osteopathic colleges of medicine be given the opportunity of internships and residencies in hospitals approved by the Joint Commission on Hospital Accreditation.

RESOLUTION NO. 12

Proposed Amendments to Ohio State Medical Association Bylaws Regarding Effect of Termination of Licensure

(By The Council, Ohio State Medical Association)

WHEREAS, The Ohio General Assembly recently enacted Section 4731.291, Revised Code, to provide for the issuance of a temporary certificate to practice medicine and surgery to persons who hold the degree of Doctor of Medicine and who wish to pursue internship, residency, or fellowship programs in the state (but who have no intention of remaining in the state after the completion of such programs), entitling the holder of such temporary certificate to perform such acts as may be prescribed by or incidental to the internship, residency, or fellowship program; and

WHEREAS, The duration of such temporary certificate is for a period of one year, but may be renewed annually for a maximum of five years; and

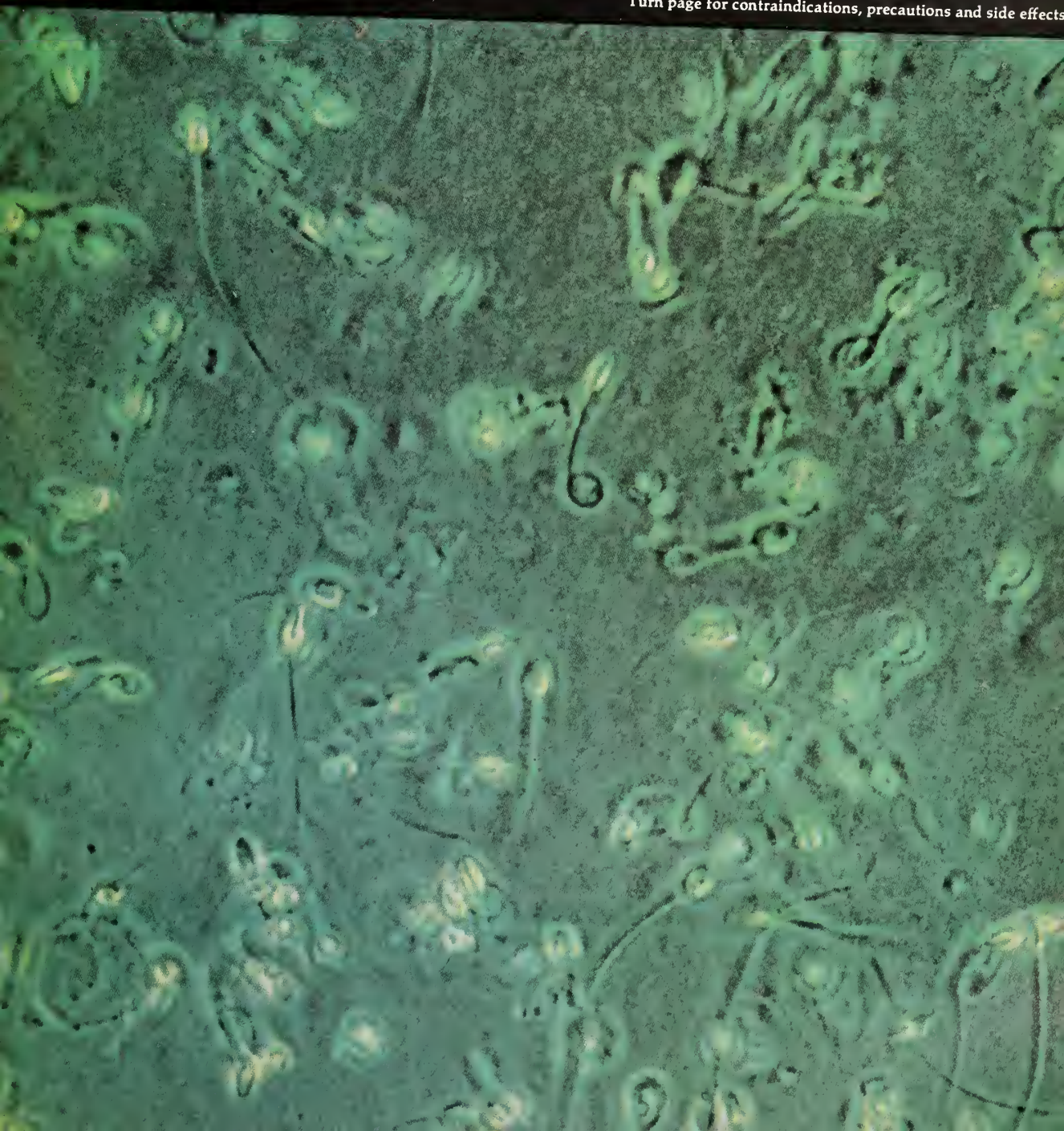
WHEREAS, Such temporary certificate may be revoked if the holder thereof engages in practice in the state outside the scope of the internship, residency, or fellowship program for which the temporary certificate has been issued or if the holder thereof is engaged in unethical conduct or has violated Section 4731.22, Revised Code; and

WHEREAS, The Ohio General Assembly recently enacted Section 4731.292, Revised Code, to provide for the issuance of a limited certificate to practice medicine and surgery to persons who hold the degree of Doctor of Medicine (but who are not citizens of the United States), and who desire to practice medicine in state-operated institutions under the supervision of the medical staff of the institution, entitling the holder of such limited certificate to practice medicine in said state-operated institutions under the supervision of the medical staff; and

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg c mestranol 0.05mg)

Turn page for contraindications, precautions and side effects



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating) breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretion suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic) rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, change in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itch.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmonary embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine, decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

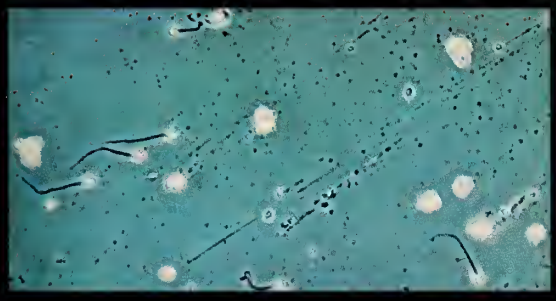
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

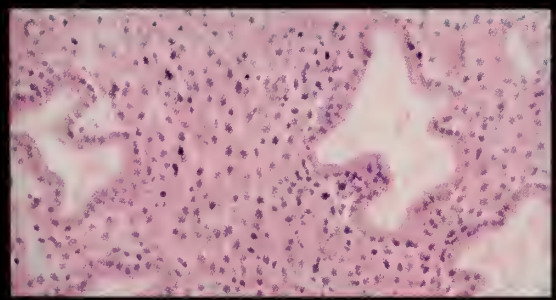
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

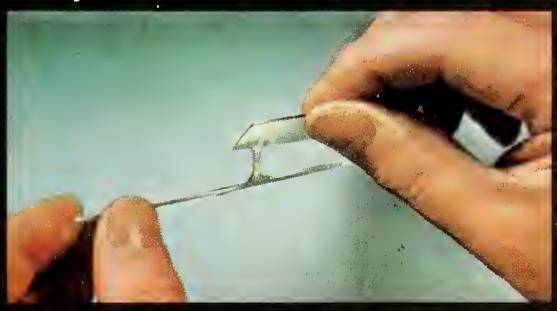


Spermatozoa appear healthy, active, freemoving.

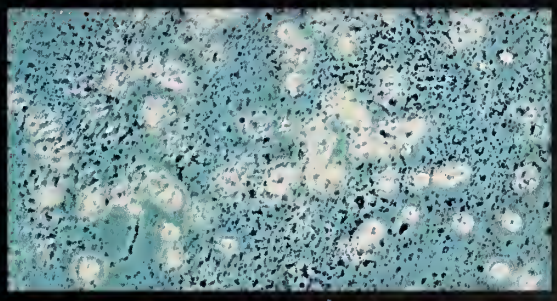


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

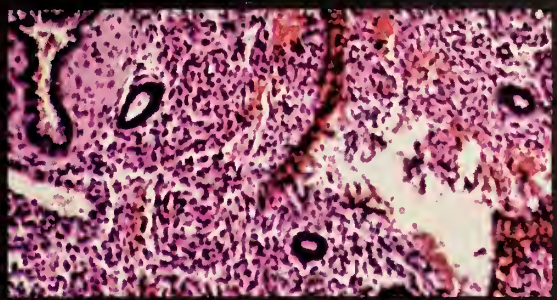
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. & mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension
cause of the possibility of p
sion of renal damage, perio
determination of the BUN is
cated. Discontinue if the BU
or liver dysfunction is aggra
Hepatic coma may be preci
Electrolyte imbalance, sodi
or potassium depletion may
If potassium depletion shou
cur during therapy, Hygroto
be discontinued and potass
supplements given, provide



Did Dorothy Larson show you her ankles in private?

Now she shows them in public.

Hygroton® Geigy
chlorthalidone

Your office examination confirmed Mrs. Larson's ankle edema.

You prescribed Hygroton—to get rid of the edema.

And you found that Hygroton is not only effective; it frequently costs less than other equivalent therapy.

A nice way to treat the Mrs. Larsons in your practice.

Hygroton therapy may mean troublesome side effects for some patients. A summary of the prescribing information is shown below.

does not have marked oli-

ecial care in cirrhosis or schemic heart disease and nts receiving corticoste- CTH, or digitalis. Salt re- is not recommended.

Reactions: Nausea, gastric n, vomiting, anorexia, con- n and cramping, dizziness, ss, restlessness, hyperglyhyperuricemia, headache, cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)R46-230-D

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-5576R

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.
Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.
Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.
Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



"Nothing else I've tried seems to work, so I decided to give you a crack at it."

WHEREAS, The duration of said limited certificate is for a period of one year, but may be renewed up to four times; and

WHEREAS, Such limited certificate may be revoked if the holder thereof engages in practice in this state outside the scope of his certificate or if the holder thereof is engaged in unethical conduct or has violated Section 4731.22, Revised Code; and

WHEREAS, The Bylaws of the Ohio State Medical Association do not provide that a certificate to practice medicine in Ohio shall be a condition of both acquiring and retaining membership in Ohio State Medical Association; NOW, THEREFORE, BE IT

RESOLVED, That subparagraph (b) of the second paragraph of Section 4 of Chapter 1 of the Bylaws of the Ohio State Medical Association be, and the same hereby is, amended to read as follows:

(b) He must hold a limited, temporary, or unlimited certificate to practice medicine and surgery, issued by the licensing authority of the State of Ohio, which license is, at the time of application for membership in this association, in full force and effect.

BE IT FURTHER RESOLVED, That Chapter 1 of the Bylaws of the Ohio State Medical Association be, and the same hereby is, amended by the enactment of Section 7, to read as follows:

"Sec. 7. Effect of Expiration, Revocation, or Termination of Certificate. Membership in this association of a member whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be canceled automatically as of the effective date of such expiration, revocation, or termination."

BE IT FURTHER RESOLVED, That Section 7 of Chapter 11 of the Bylaws of the Ohio State Medical Association be, and the same hereby is, amended to read as follows:

"Sec. 7. Effect of Expiration, Revocation, or Termination of Certificate. Membership in a component society of a member of such society whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be canceled automatically as of the effective date of such expiration, revocation, or termination."

RESOLUTION NO. 13

Permission for Autopsy

(By the Knox County Medical Society)

WHEREAS, The performance of postmortem examinations in other than medicolegal circumstances, is recognized as a valuable aid in postgraduate medical education, and

WHEREAS, It is necessary to obtain permission for such examination from the "next of kin" of the deceased person, and

WHEREAS, It is often difficult to determine who is the "next of kin," and

WHEREAS, There is no statute of the State of Ohio defining "next of kin" for purposes of giving permission of autopsy, thus making it often times impossible to be certain that valid permission has been obtained, NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association request The Council of the Ohio State Medical Association, with the aid of its staff and its legal counsel, to cause legislation to be introduced at the next session of the Ohio Legislature to define "next of kin" for the purpose of giving permission for postmortem examination.

RESOLUTION NO. 14

Shortage of Doctors of Medicine

(By the Stark County Medical Society)

WHEREAS, A definite shortage of Doctors of Medicine exists in certain areas of Ohio as well as in certain areas of the United States, and

WHEREAS, The medical schools of the United States exert a powerful influence as regards the medical students' choice of medical activities after graduation, and

WHEREAS, The percentage of medical students entering the private practice of medicine appears to be declining annually, NOW, THEREFORE, BE IT

RESOLVED, That, beginning in 1969, each medical school in the United States file an annual report with the House of Delegates of the Medical Association of the state wherein the medical school is located; such report to state in detail what programs are being undertaken to present to the students the advantages of the private practice of medicine and, more specifically, the general practice of medicine, AND BE IT FURTHER

RESOLVED, That failure to file such a report will result in the withholding of AMA-ERF funds until such report is filed; AND BE IT FURTHER

RESOLVED, That the Council of Medical Education and the Council of Medical Service of the American Medical Association be instructed to pursue a course that will encourage young physicians to enter the private practice of medicine.

RESOLUTION NO. 15

Truth in Labeling

(By the Summit County Medical Society)

(Text of this resolution included in packet for members of the House of Delegates.)

RESOLUTION NO. 16

Hospital-based Physicians

(By the Summit County Medical Society)

PREAMBLE

It is our intention to express the appreciation and respect of the medical profession in Ohio to those hospital-based physicians who have implemented the separate establishment, billing and collecting of their professional fees from the charges of hospitals.

WHEREAS, With unusual initiative and personal difficulty the members of the association practicing hospital-based specialties have contributed significantly to the Ohio State Medical Association policy implementation by separating their charges and billing them in like manner to all other physicians, THEREFORE, BE IT

RESOLVED, That the House of Delegates at its annual meeting, 1968, commend these members for their exemplary contribution to the best interest of the profession and the public.

RESOLUTION NO. 17

Ohio AMA Delegation and Osteopathy

(By the Summit County Medical Society)

PREAMBLE

The purpose of this resolution is to commend the Ohio State Medical Association Delegation to the American Medical Association for its efforts seeking a national solution to the MD - DO impasse. Apparently the relationship of the two groups varies widely from state to state and this adds to the difficulty of standard policies at the national level.

BE IT RESOLVED, That the OSMA House of Delegates commends our AMA delegation for its efforts to develop national policy in the field of MD-osteopath relations, and BE IT FURTHER

RESOLVED, That it direct the delegation to continue its valiant labors along the lines it has pursued — namely, acceptance of osteopathic graduates as house officers in AMA-approved hospitals where they can be professionally evaluated and trained.

RESOLUTION NO. 18
Standards for Medical Records

(By the Summit County Medical Society)

WHEREAS, The standards for hospital accreditation are set forth by the Joint Commission on Accreditation of Hospitals, and

WHEREAS, Conformity to the requirements for medical records as set forth by the Joint Commission is a prerequisite for hospital privileges for all physicians in accredited hospitals in the State of Ohio, and

WHEREAS, The requirements for medical records vary widely among the hospitals in the State of Ohio, even among hospitals in the same community, and

WHEREAS, The current requirements for medical records involve duplication and even triplication of information within a given medical record, resulting in an extraordinary waste of physician time, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association petition the American Medical Association to prevail upon the Joint Commission on Accreditation of Hospitals to create a uniform set of regulations for medical records eliminating useless duplication of effort.

RESOLUTION NO. 19
HEW and Group Practice

(By the Summit County Medical Society)

PREAMBLE

The purpose of this resolution is to protect the solo and homogeneous group practice of medicine against the attempts of the government and some multispecialty groups to discredit and destroy solo and homogeneous group practice. It is the further purpose to protect solo and homogeneous group practice against the stated purposes of government and some multispecialty groups to encourage the practice of medicine by hospital-based groups and Federally supported and operated programs.

WHEREAS, In the past, solo and multispecialty group practice have existed side by side and have developed according to the needs and desires of the providers and consumers of medical services, and

WHEREAS, There is now a concerted effort on the part of the Federal Government and some multispecialty groups to discredit the quality of medical care provided by solo and homogeneous group practice and to foster multispecialty group practice centered around hospitals and medical schools under Federally supported and operated programs, and

WHEREAS, There is no proof that one method of practice consistently provides better patient care than the other or at a lower cost, and

WHEREAS, We feel that the support of multispecialty group practice by the government is a subterfuge to weaken the position of organized medicine, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association protest and work against the actions and use of Federal funds by agencies of the Federal or State Government which favor the development of one type of practice over the other, and BE IT FURTHER

RESOLVED, That the OSMA delegation to the AMA pursue the adoption of a similar resolution by the House of Delegates of the American Medical Association.

RESOLUTION NO. 20
Surgical Technicians

(By the Academy of Medicine of Cleveland)

WHEREAS, The problem of staffing operating room theaters with trained technical assistants is becoming increasingly difficult each year,

WHEREAS, The need for paramedical personnel is widely recognized, and

WHEREAS, Qualified institutions of higher learning are developing satisfactory courses of instruction to train surgical technicians, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association endorse the training and use of such personnel in surgical operating units and request that the American Medical Association and the American College of Surgeons establish requirements for such programs leading to registration.

RESOLUTION NO. 21
Physician Members on Hospital Governing Boards

(By the Academy of Medicine of Columbus and Franklin County)

WHEREAS, Physicians are generally sparsely represented on hospital governing boards; and

WHEREAS, Such lack of representation has led to, and can lead to, unnecessary misunderstandings between medical staffs and hospital governing boards; and

WHEREAS, Most physicians are acutely aware of hospital problems, in many cases more so than nonphysician members of hospital governing boards; and

WHEREAS, Many parochial institutions are modernizing to encourage representation of the laity on their governing boards; and

WHEREAS, The AMA has already approved the principle of having physician members on hospital governing boards; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association be directed to encourage through its publications and through the component county medical societies the election and/or appointment of physicians with full voting privileges to the boards of trustees of hospitals.

RESOLUTION NO. 22
Reorganization of Health Agencies

(Submitted by H. William Porterfield, M. D., a Delegate, Columbus Academy of Medicine)

WHEREAS, Federal tax spending includes billions of dollars for scores of federally assisted medical and health projects; and

WHEREAS, There are multiple, overlapping federal and state agencies making funds and grants available for studies, projects, and programs; and

WHEREAS, Many of these activities are funded or approved by various agencies of the State of Ohio; and

WHEREAS, This tends to create confusion, misunderstanding, duplication, and waste of federal and state tax monies, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association exert every effort to achieve in this state the organization and implementation of a free-standing state agency to coordinate and administer the approval of all such grants, funds, and projects, AND BE IT FURTHER

RESOLVED, That this Association and other similarly established and recognized scientific associations in Ohio be responsible for establishing the policies and administrative procedures of this agency, AND BE IT FURTHER

RESOLVED, That the Ohio delegation to the American Medical Association be instructed to present to that Association's House of Delegates a resolution directing that the AMA use every means and resource available to achieve the establishment of a separate U. S. Department of Health of rank and status equal to the other Federal Departments of cabinet rank, AND BE IT FURTHER

RESOLVED, That the AMA and every component society use every means and resource available to establish single state health agencies for the implementation of all health programs within the individual state.

Candidate for the Office of OSMA President-Elect

IN ACCORDANCE with Section 1 (a) of Chapter 5 of the OSMA Bylaws, the following nomination of a candidate for the office of President-Elect has been filed with the Executive Secretary 60 days prior to the meeting of the House of Delegates at which the election is to take place:



ROBERT N. SMITH, M.D.
TOLEDO, OHIO

The Academy of Medicine of Toledo and Lucas County

March 8, 1968

Mr. Hart F. Page
Executive Secretary
Ohio State Medical Association
17 South High Street
Columbus, Ohio 43215

Dear Mr. Page:

By constitutional privilege, we nominate Robert N. Smith, M. D., the Fourth District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association.

Doctor Robert N. Smith is qualified by membership in good standing in the Academy of Medicine of Toledo and Lucas County, the Ohio State Medical Association and the American Medical Association.

Respectfully submitted,

Edmund F. Glow, M. D.
Chairman of Delegates

John S. Kozy, M. D.
President

Curriculum Vitae

Office: Doctors Building, 3939 Monroe St., Toledo 43606

Residence: 3424 Gallatin Road, Toledo 43606

Practice: Anesthesia
Diplomate of American Board of Anesthesiology

Professional Society Membership:
American Society of Anesthesiology
Ohio Society of Anesthesiology
American Medical Association
Ohio State Medical Association
Academy of Medicine of Toledo and Lucas County

Birthplace: Toledo, April 2, 1920

Education: United States Military Academy — B. S., 1943; Massachusetts Institute of Technology — M. S., 1945; University of Nebraska College of Medicine — M. D., 1952

Military Service: U. S. Air Force — Pilot 1943-1948

Hospital Appointments:
Toledo Hospital
Mercy Hospital
Riverside Hospital

Medical Organization Activities:
Local: Polio Vaccine Program — Medical Director
Disaster Medical Care — Chairman
Treasurer of Academy
Member of Numerous Committees

State: OSMA Councilor, Fourth District, 1963 to Present; Re-Elected in 1965 and 1967

OSMA Committee on Auditing and Appropriations

OSMA Committee on Legislation

OSMA Committee on Redistricting

OSMA Advisory Committee to the Ohio State Society of Medical Assistants

Chairman of Nominating Committee for the Board of Ohio Medical Indemnity

(Continued on Next Page)

National: Alternate Delegate to the American Medical Association

Community Organization Activities:

Member, Board of Hearing and Speech Center

Advisor to American Red Cross from Academy of Medicine

Member, Parent-Teacher Association

Member, Chamber of Commerce, Rotary Club, Masonic Lodge, Scottish Rite

Fraternal Organizations: Member of Nu Sigma Nu, Chi Phi, Sigma Xi, and Alpha Omega Alpha

Family: Married to the former Marilyn Jane Collins of Columbus

Children: Sandralyn and Sharen, both married; and at home, Robert, Jr., Marilyn Ann, Marcia Jeanne, and Elizabeth

Two brothers, both physicians

Members of St. Michael's in the Hills Church

Deadline Set on Abstracts of Papers for Heart Program

June 7 has been set as the deadline for abstracts of papers to be presented at the American Heart Association 1968 Scientific Sessions.

The sessions, extended this year to four days, from Thursday, November 21, through Sunday, November 24, will be held in the Americana Hotel, Bal Harbour, Florida.

Papers should be based on original investigations in, or related to, the cardiovascular field. Abstracts must digest the project's results and the investigator's conclusions. Applications must be submitted on official forms, which may be obtained from the Department of Medical Education at the AHA national office, 44 East 23rd Street, New York, New York 10010.

Applications for cardiovascular films and scientific exhibits to be considered for presentation at the sessions also may be secured from the American Heart Association national office and must be mailed by June 7.

Ohio Medical Practice Act . . .

Medical Board Executive Secretary Discusses Improvements Being Made in Licensing Procedure Under the Revised Act

By W. THOMAS WASHAM, M.D., LL.B.
Executive Secretary, State Medical Board of Ohio

THE MEDICAL PRACTICE ACT of the State of Ohio has been substantially revised and a great step forward has been taken during the 107th General Assembly with the all-out support and leadership of the Ohio State Medical Association.

For better or worse, you should be very proud of this accomplishment. This legislation is the first broad revision of the Medical Practice Act in more than half a century, but should be considered only the initial effort in a continuing program of revision.

Ohio is receiving very favorable national attention and comment for this revision of its Medical Practice Act and the new type of licensing examination which will be initiated in June. We are in the process of evolving a new type of examination with the objective of testing clinical competence to practice as well as recall of factual information. The first two days of examinations, testing the areas of basic sciences and clinical sciences, will present questions more clinically related than previous examinations.

The third day will consist of three phases or sections, testing clinical competence or fitness to practice.

The first phase will consist of sequences of motion pictures of patients which will be interrupted and followed by a series of questions on what the applicant has just observed. The object here is to provide an objective and reliable means of evaluating the ability of the physician to observe a patient accurately and arrive at an appropriate conclusion based upon his observations.

The second phase deals with clinical material in the form of still pictures of patients or specific lesions, or gross or microscopic specimens. This section also includes questions related to the interpretation of roentgenograms, electrocardiograms, funduscopic views,

The text of a lecture presented by Dr. Washam before the Annual Conference for County Medical Society Officers, Columbus, February 25, 1968.

blood smears or other clinical material that can be shown pictorially or graphically with the use of color reproduction when color is needed.

The third phase of our Part III examination is a new and quite different method devised to test other, but closely related, aspects of clinical competence dealing with the ability to identify, to resolve and to manage the problems of patients. This method simulates the realistic clinical situation in which the physician is called upon to face the dynamic challenge of the sick or injured patient. As in real life, the candidate is confronted with a patient about whom he may have limited information. He must study the available information, and then he must decide what to do. He may require laboratory determinations and diagnostic procedures; he must arrive at decisions about therapy and management.

In the test booklet a list of possible procedures immediately follows the description of the patient. Some of these procedures are correct and mandatory for the proper management of the patient. Other choices in the list are incorrect or contraindicated. The candidate is not told how many procedures or courses of action are considered correct; his task is to select those that he judges to be appropriate at this point in time. After he has decided upon a course of action, he then is instructed to turn to a separate answer booklet, where he finds a series of inked blocks, each block numbered to correspond to one of the given choices. He erases the ink for his selected choices with an ordinary pencil eraser, and the results of his decisions are revealed. Thus, he gains additional information from his decisions -- from the courses of action that he selects.

The situation has now changed; a new problem evolves, and again decisions and actions are called for in the light of the new information and the altered circumstances. A second series of choices of what to do constitutes a second problem for this patient, and again the candidate reaches his decisions and turns to the answer booklet to discover, by erasing the appropriate inked blocks, the consequences of his second series of decisions.

He continues in this manner through some four to six problems that follow the patient's course for a period of days, weeks or months, until the patient improves and is discharged from the hospital, or possibly has died.

Ohio will not only be one of the first states to use this new examination, which two members of our Board, Dr. Frederick T. Merchant and Dr. Lloyd R. Evans played major roles in creating, but is leading the way for other states.

Areas which are modified by the new legislation include extending the statutory definition of grossly unprofessional conduct, for which a certificate to practice may be suspended or revoked, to include violation of any provision of a code of ethics of a national professional organization, with the American Medical Association, American Osteopathic Association, American Chiropractic Association, and American Podiatry Association being specified.

This provision will provide additional sanctions for ethical violations by members of the various professions under the jurisdiction of the State Medical Board and should enable the Board effectively to handle violators who are not members of professional organizations.

Incompetency Covered

New statutory authority has been provided for the Board in regard to mental illness or mental incompetency of a licensee. Under this section the secretary or a member of his staff may file an affidavit initiating probate proceedings. The Board will be represented by the Attorney General in these proceedings. If the licensee is found by a probate court to be mentally ill or incompetent, his certificate to practice is automatically suspended until such person has filed with the Board satisfactory proof of his restoration to competency.

Another new statute permits the Board, where a certificate to practice has been in a suspended or inactive state for any cause for more than two years, to require the applicant to pass an oral or written examination, or both, to determine his present fitness to resume practice. The Board may require such an individual to obtain additional training and may also restrict or limit his extent, scope, or type of practice.

These provisions should aid the Board in situations where professional competency is at issue.

Biennial Registration

The new legislation requires the biennial registration of all doctors of medicine licensed to practice in the State of Ohio on or before the first day of January of each odd numbered year. The registration fee is ten dollars.

The biennial registration will enable the Board to control more effectively problems concerning transient physicians, provide statistical information as to the distribution of physicians and the various types of medical practice within the state. Each registrant will be mailed a directory of the practitioners so registered with both alphabetical and geographical listings.

The previous requirement that osteopathic physicians and surgeons pass a supplemental examination to be eligible for licensure by endorsement has been eliminated.

The Board may now register persons holding the degrees of doctor of medicine or doctor of osteopathic medicine and surgery who wish to pursue accredited internship, residency, or fellowship programs in the state and issue to these applicants temporary certificates which will entitle the holder to perform

such acts as may be prescribed by or are incidental to such supervised programs. The temporary certificate does not entitle the holder to engage otherwise in professional practice and may be revoked by the Board for such conduct.

This legislation was enacted at the request of many hospitals and the colleges of medicine within the state.

Limited Certificates

There is a new statutory authority for the Board to issue limited certificates to noncitizens to practice in hospitals operated by the State. These individuals will be required to pass the regular State Medical Board Examination for issuance of this limited certificate. A holder of such a limited certificate to practice, upon completion of the requisite training and upon receipt of his United States citizenship will be entitled to receive an unlimited certificate to practice. The limited certificate to practice in hospitals operated by the State does not entitle the holder to practice outside the physical confines of the institution and must be renewed annually. Renewals are limited to a maximum of four times.

This legislation should aid the State institutions in maintaining adequate professional staffs. The requirement that these individuals successfully pass the regular Board examination was considered desirable for the protection of the public.

The new legislation also made available to the State Medical Board, effective January 1, 1969, an injunction procedure by which a person engaged in the practice of medicine in all of its branches, the treatment of human ailments without the use of drugs or medicines and without operative surgery, or in the practice of midwifery without a valid and current certificate to do so, could be enjoined from so engaging.

Similar legislation has on previous occasions failed to muster the necessary support for legislative approval.

The old statutes governing midwifery were repealed and new statutes drafted which provide for the certification of registered, graduate nurses who are also graduates of a school or college for nurse midwives. Applicants for certification must pass an examination given by the State Medical Board and must conduct their practice under the supervision and direction of a properly licensed doctor of medicine or doctor of osteopathic medicine and surgery.

The statutory definition of the legally permissible scope of the practice of podiatry was revised. The new definition provides that the podiatrist may treat the local manifestations of systemic disease, but that the patient shall be concurrently referred to a doctor of medicine or doctor of osteopathic medicine and surgery for the treatment of the systemic disease itself.

We are hopeful that the concurrent referral will result in closer cooperation and better understanding between the professions.

Additional changes included providing for a ten-dollar fee for certification of a licensee to another state, increasing the examination fee from fifty to seventy-five dollars and elimination of a free second examination for those failing their first examination.

The penalty section of our statutes was revised so that the specified fines were increased to levels more in accord with present-day economic standards.

Office and Staff

As a result of the successful passage of this new legislation, we are engaged in re-organization of the Medical Board offices and staff.

Our new staff has the potential of developing into the type of organization which can efficiently carry out the functions of the agency. Right now, we lack the essential ingredient of experience as our daily problems and tasks have amazing variety which makes the development of workable routines difficult. Bear with us and do not expect miracles overnight — we are getting better and I promise you progress will continue.

My two new top assistants are Mr. Howard Ramsey, who is the administrative assistant and in charge of our staff of investigators, and Mrs. Florence Parsons, who is our office supervisor. I request that you do not hesitate to discuss any Medical Board-related problems you may have with either of these individuals as they are very competent, have good backgrounds for this work and pride in doing a good job. They are my right arms in carrying out Board policies.

I guess the time has now come in my sermon to give thanks and it is impossible to express adequate appreciation for the back-home support your groups rendered. I do sincerely thank you because it could not have been done without your help.

We also have reason to be grateful to some allied organizations for their needed support. These include, in addition to the colleges of medicine within the state, the Ohio State Osteopathic Association, the Ohio State Podiatry Association, and the Ohio Hospital Association.

In our gratitude we should not forget Representative Keith McNamara, the sponsor of our Bill.

We also owe a vote of thanks to the Ohio State Medical Association officers and Council for their efforts which we too often take for granted.

We owe special thanks to the staff of the Ohio State Medical Association, Hart, Chuck, Herb, and Jerry for not only their creative efforts, but the long exhausting hours spent monitoring this last legislative session. I personally know of many, many 18-hour days which were put in by them in our behalf. I want to use this occasion to personally thank them again.

OMPAC and the 1968 Elections . . .

Political Action Committee Needs Many More Members Before the All-Important 1968 Election Campaigns Go into Full Operation

THE Ohio Medical Political Action Committee has gotten off to a great start with membership climbing during the early months of 1968, but many more Ohio members are needed if OMPAC is to top its performances in the General Elections of two years ago. During the 1966 General Elections, OMPAC racked up a tremendous record of performance by backing candidates who reflect medicine's point of view in the Ohio legislature and in the U. S. Congress.

During 1966, OMPAC membership was 2989. For the first 12 weeks of this year membership was climbing and had reached the 2375 membership mark. Memberships are still coming in, but many more are needed if OMPAC is to represent the thinking of Ohio physicians during the 1968 election campaigns.

Physicians who have not made their 1968 contributions to OMPAC-AMPAC may do so through their county medical society treasurers.

Here are some figures by counties for comparison — State Association membership as of the first of the year; OMPAC membership during the General Election year of 1966, and OMPAC membership this year to the middle of March:

	OSMA	OMPAC 1967	OMPAC 1968
First District			
Adams	10	1	5
Brown	17	7	2
Butler	185	78	55
Clermont	23	4	0
Clinton	19	5	8
Hamilton	1262	427	349
Highland	17	0	1
Warren	15	11	1
	1548	533	421
Second District			
Champaign	17	8	8
Clark	131	54	45
Darke	25	7	8
Greene	54	19	17
Miami	67	37	37
Montgomery	577	224	220
Preble	7	0	4
Shelby	24	15	20
	902	364	359
Third District			
Allen	129	70	79
Auglaize	19	2	8
Crawford	40	35	21
Hancock	46	3	7
Hardin	27	0	4
Logan	15	0	2
Marion	67	14	6
Mercer	18	2	4
Seneca	43	23	16
Van Wert	20	10	5
Wyandot	11	3	2
	435	162	154

	OSMA	OMPAC 1967	OMPAC 1968
Fourth District			
Defiance	24	4	10
Fulton	17	3	0
Henry	12	7	0
Lucas	632	61	4
Ottawa	22	8	11
Paulding	8	11	2
Putnam	11	1	5
Sandusky	48	14	8
Williams	17	0	0
Wood	38	4	8
	829	103	48
Fifth District			
Ashtabula	61	17	14
Cuyahoga	2311	415	281
Geauga	27	10	8
Lake	104	57	60
	2503	499	363
Sixth District			
Columbiana	73	5	11
Mahoning	349	91	79
Portage	58	29	17
Stark	355	181	118
Summit	572	88	2
Trumbull	132	58	2
	1539	452	229
Seventh District			
Belmont	53	19	26
Carroll	10	6	7
Coshocton	23	1	1
Harrison	7	6	5
Jefferson	66	4	18
Monroe	3	0	0
Tuscarawas	53	26	20
	215	62	77

	OSMA	OMPAC 1967	OMPAC 1968
Eighth District			
Athens	10	13	0
Fairfield	51	36	31
Guernsey	26	4	2
Licking	68	14	10
Morgan	3	0	0
Muskingum	75	26	36
Noble	2	1	0
Perry	6	3	1
Washington	31	0	0
	302	97	80
Ninth District			
Gallia	35	4	10
Hocking	9	1	0
Jackson	15	0	5
Lawrence	22	15	14
Meigs	6	0	0
Pike	9	0	0
Scioto	65	33	31
Vinton	1	1	0
	162	53	60
Tenth District			
Delaware	26	7	7
Fayette	15	12	14
Franklin	951	418	299
Knox	33	25	16
Madison	13	2	4
Morrow	8	2	5
Pickaway	20	6	9
Ross	42	21	22
Union	16	2	2
	1127	495	378
Eleventh District			
Ashland	26	6	10
Erie	63	0	27
Holmes	10	7	5
Huron	29	14	20
Lorain	204	58	44
Medina	56	18	19
Richland	120	37	47
Wayne	61	29	34
	569	169	206
Totals	10,131	2989	2375

Obituaries

Ad Astra

Earl Wesley Doty, M. D., Long Beach, Calif.; University of Cincinnati College of Medicine, 1943; aged 56; died February 25; former member of the Ohio State Medical Association. A former resident of Cincinnati, Dr. Doty moved to California many years ago. He is survived by his widow, two sons, and three sisters.

Karl H. Feistkorn, M. D., Marion; Ohio State University College of Medicine, 1935; aged 58; died February 18; member of the Ohio State Medical Association and the American Medical Association. A general practitioner, Dr. Feistkorn moved to Marion in 1937. During World War II he served in the Army Medical Corps, and after the war became associated with the Ohio State University Health Service. In 1956 he returned to his practice in Marion. A member of the Methodist Church and the Lions Club, he is survived by his widow.

Hortense B. (Schmitz) Kuhr, M. D., Dayton; Western Reserve University School of Medicine, 1939; aged 54; died February 24; member of the Ohio State Medical Association, the American Medical Association, and the American Thoracic Society. Dr. Kuhr practiced for about 20 years in Dayton in association with her husband, Dr. Abe Kuhr. Before her marriage she practiced for about five years in Cleveland. A member of the Temple, she is survived by her husband, four daughters, and a sister.

John H. Lazzari, M. D., Lakewood; Western Reserve University School of Medicine, 1931; aged 63; died February 14; member of the Ohio State Medical Association, the American Medical Association, Central Surgical Association, James Ewing Society; Fellow of the American College of Surgeons; Diplomate of the American Board of Surgery. A physician and surgeon of long standing in Cleveland, Dr. Lazzari was named "Man of the Year" in 1958 by the Ohio Division of the American Cancer Society. He was a past president of the Ohio Division and a director of the American Cancer Society. During World War II he served in the Army Medical Corps with the rank of lieutenant colonel. Among survivors are his widow, a daughter, a son, his mother, five brothers, and two sisters.

Domenic Anthony Macedonia, M. D., Steubenville; Ohio State University College of Medicine, 1935; aged 57; died February 26; member of the Ohio State Medical Association and the American Medical Association; Fellow of the International College of Surgeons. A native of Steubenville and practitioner there for virtually all of his professional



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e sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
e hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
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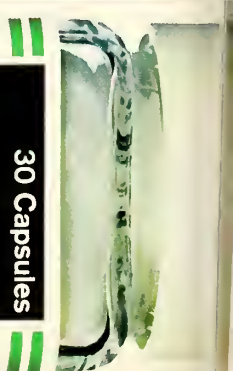


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Niacinamide	50 mg
Calcium pantothenate	10 mg
Ascorbic acid (Vit. C)	300 mg



career, Dr. Macedonia was identified with the medical, civic, religious, and political life of his community. In 1961 he was named a member of the State Medical Board of Ohio and in 1965 became Board President. Only recently he had become a member of the Board of Elections of Ohio. Dr. Macedonia's practice was in the field of ophthalmology and otolaryngology, specialties he qualified himself for at the Metropolitan Hospital in New York City. He was a member of the Steubenville Board of Health, and was affiliated with the Fort Steuben Academy of Medicine. Another affiliation was with the Ohio Lions' Eye Research Program, as chairman of its medical advisory board and as its director and past president. He was a member and past president of the College of Steubenville and a member of its founders' association; also active in several local sports programs. Long active in the political arena, he was chairman of the Jefferson County Democratic Party. The highest honor that can come to a Catholic layman was accorded him when Pope Pius XII designated him Knight Commander of St. Gregory with Star in 1952. He also was commended by the Bishop of the Steubenville Diocese who awarded him the Caritas Medal. The Italian government honored him with the Cross of Solidarity. A Fourth Degree member of the Knights of Columbus, he served as master of the Southeast Ohio District of that organization. On February 29 the Ohio General Assembly passed a memorial resolution by adopting H. R. 199, "in tribute and respect to the memory of Dr. Domenic A. Macedonia of Steubenville, humanitarian and outstanding citizen." He is survived by his widow, two daughters, and three sons, among them Dr. John Joseph, intern at Mt. Carmel in Columbus, and Domenic, Jr., medical student at Ohio State University. Two sisters also survive.

John Charles Mihalek, M. D., Cleveland; Western Reserve University School of Medicine, 1943; aged 51; died February 5; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Mihalek practiced there for about 21 years, engaging in general practice. He is survived by his widow, two daughters, two sons, his mother, and two sisters.

John Adam Mooney, M. D., New Bethlehem, Pa.; University of Michigan Medical School, 1924; aged 71; died December 15; member of the Ohio State Medical Association and the American Medical Association. Dr. Mooney moved his practice to Kenton from Michigan during the 1930's and practiced in the Hardin County area until his retirement.

William J. Retzer, Sr., M. D., Cleveland; Baltimore University School of Medicine, 1930; aged 64; died February 14; member of the Ohio State Medical Association. A practicing physician of long standing in Cleveland, Dr. Retzer was medical director of the Dow Chemical Company plant, and examiner for the Brotherhood of Railroad Trainmen. He was a member of the Catholic Church and the Holy Name Society. Among survivors are his widow, a daughter, two sons, and a brother.

Lucille Richardson, M. D., Grosse Pointe, Mich.; Ohio State University College of Medicine, 1950; aged 51; died February 29; former member of the Ohio State Medical Association. Dr. Richardson practiced for about eight years in Toledo. For the last six years she had been on the staff of the Henry Ford Hospital in Detroit. Two brothers survive.

Hugh J. J. Savage, M. D., Cleveland; Ohio State University College of Medicine, 1917; aged 76; died March 3; member of the Ohio State Medical Association and the American Medical Association. A career public health officer, Dr. Savage was associated for many years with the Division of Health of Cleveland. He was a member of the Catholic Church and the Knights of Columbus.

Andrew Shawala, M. D., Pleasant City; Lekarska University Faculty of Medicine, Bratislava, Czechoslovakia, 1930; aged 71; died February 8; member of the Ohio State Medical Association and the American Medical Association. With a total of 35 years of practice, Dr. Shawala had been in the Pleasant City area for about seven years. A member of the Catholic Church, he is survived by his widow, two sisters, and three brothers.

Douglas G. Sroufe, M. D., Mt. Orab; Ohio State University College of Medicine, 1933; aged 65; died February 1; member of the Ohio State Medical Association. A former practitioner in Madisonville, Dr. Sroufe served in the Medical Corps during World War II and after the war moved his practice to Mt. Orab. He is survived by his widow and his mother.

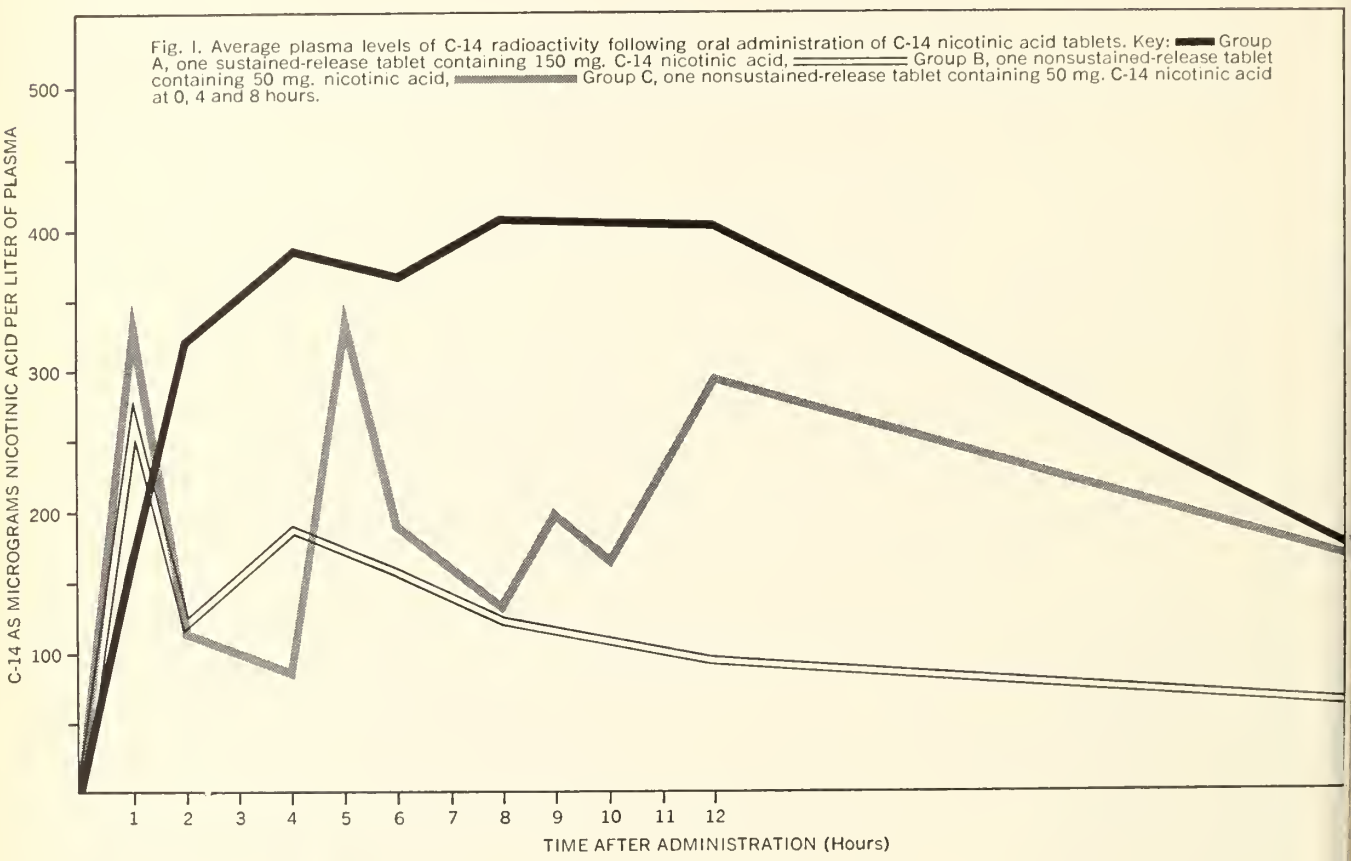
Emphysema Treatment Facilities Doubled at VA Hospitals

The Veterans Administration doubled, during 1967, the number of medical units for the treatment of emphysema, described as "the fastest growing and most alarming disease."

VA Chief Medical Director, Dr. H. Martin Engle, reported that these special units for the management of this disease now have been set up at 52 VA hospitals and that further expansion of the treatment program is planned over the next five years as funds become available.

Sustained circulatory, respirator and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

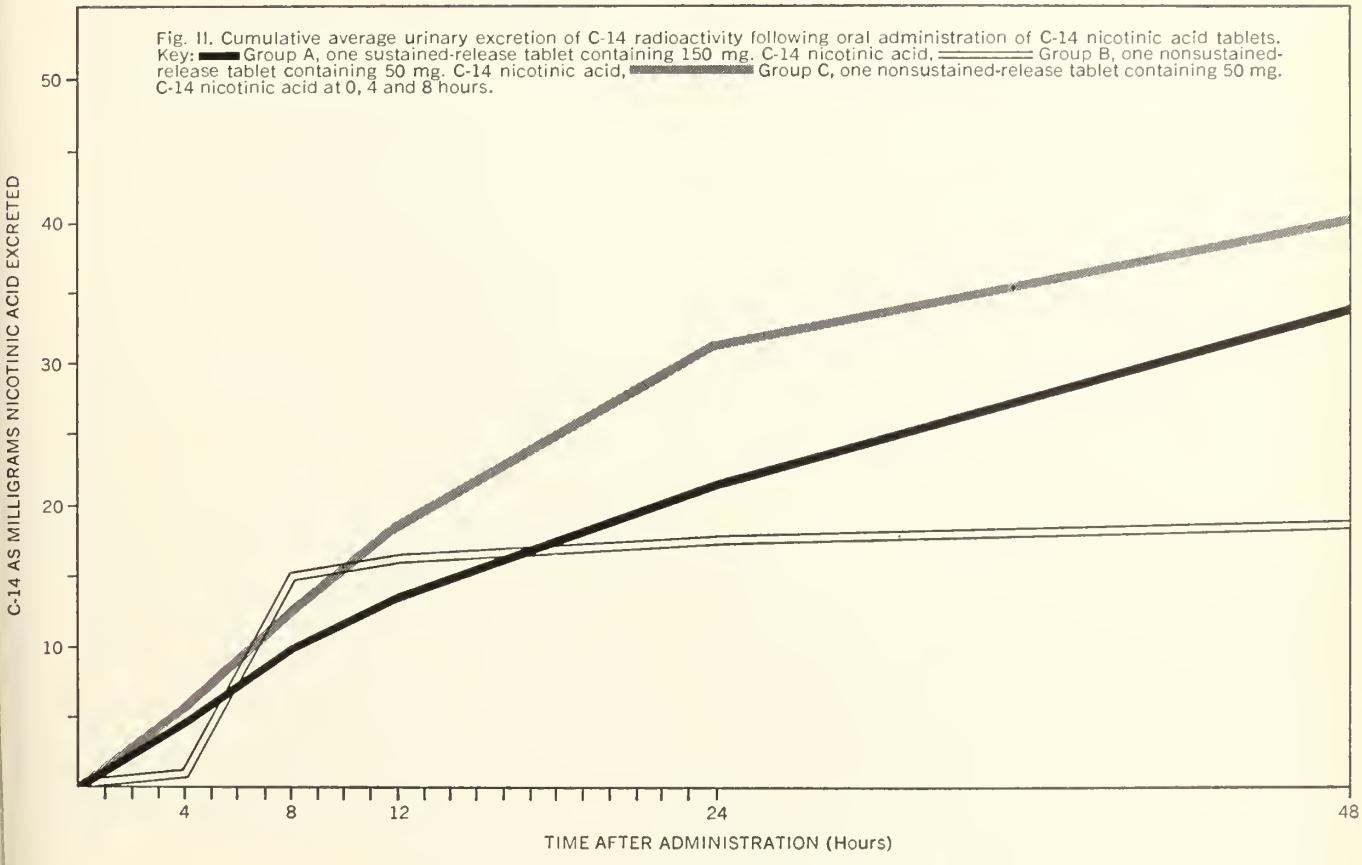
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be co tinuous on a daily dose of only one Geroniazol TT ta let every 12 hours.

The gradual release of nicotinic acid in Geroniaz TT will provide the well-known peripheral vasodilat tion needed in patients with deficient circulation a with a minimum amount (if any) of "flushing." Als cerebrovascular circulation is complemented by pe tylenetetrazol, long-established as a cerebral and re piratory stimulant.

Geroniazol TT improves the typical, unfortunat signs of senile confusion. Patients become more ale

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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V. D. Survey in Ohio . . .

Health Officers Requests Physicians to Keep Record of Cases Diagnosed and Treated, in Anticipation of National Survey

By CALVIN B. SPENCER, M.D., Acting Chief
Bureau of Preventive Medicine, Ohio Department of Health

DURING THE PERIOD April 1st to June 30th, 1968, Ohio Physicians are asked to keep tab on the number of venereal disease cases they are diagnosing and treating. This is part of a nationwide, three month survey conducted jointly by the American Medical Association, American Osteopathic Association, National Medical Association, and the American Social Health Association. The study is designed to bring out "up-to-date" information on the extent of new infections occurring throughout the United States. The medical profession, and the general public have rightly become alarmed at the spread of these communicable diseases, especially gonorrhea.

The last survey, conducted in 1962, was open to a great deal of doubt as to accuracy because most questionnaires sent to physicians were completed from memory rather than records. We have provided the accompanying "Box-Score" which we hope you fill out as cases are diagnosed and treated during the next three months. Please cut this page out and place it where it will be an obvious reminder to you or your secretary to keep an accurate tally.

In July you will receive in the mail a simple questionnaire. It will be easy for you then to transfer the numbers from your "Box-Score" to the questionnaire. Your help is earnestly solicited to make this survey a success. Please return your completed questionnaire as soon as possible after July 1, 1968.

Before any effective control program can be instituted against V. D., we must have an accurate measure of the size of the problem. The extent of unreported V. D. has always been a speculation. Perhaps we are more concerned than we need to be. Perhaps the "epidemic" does not exist, as many people claim. It is also possible that we have all underestimated a serious medical problem which must be dealt with in a more effective manner.

The completed questionnaire which you mail in will not require identification as to its source. The information you give will only appear as numbers — so there should be no concern about medical confidence or legal implications. A successful and accurate survey will be of great importance to physicians and public alike.

	"V. D. BOX-SCORE" (April 1 - June 30, 1968)	TOTAL
Primary & Secondary (Infectious) Syphilis		
Other Stages of Syphilis		
Gonorrhea (Male & Female)		

Please clip this "box-score" and place in a convenient location for daily notations. Check marks in appropriate box will suffice for tally. In July you may transfer numbers from your box score to the questionnaire.

Activities of County Societies...

CUYAHOGA

The Academy of Medicine of Cleveland featured a Symposium on Drug Poisonings at the Academy headquarters on the afternoon of March 20. The following topics and speakers were on the program:

"Management of the Poisoned Patient," Dr. Harry C. Shirkey, professor of pediatrics, Medical College of Alabama.

"Diagnosis and Treatment of Drug-Produced Coma," Dr. Jerome B. Posner, associate professor of neurology, Cornell University Medical College.

"Salicylate Intoxication and the Use of Dialysis in the Treatment of Poisoning," Dr. Alan K. Done, associate professor of pediatrics, University of Utah.

"A Breakthrough in the Treatment of Addiction," Dr. Efren Ramirez, coordinator of Addiction Program for New York City.

FRANKLIN

"Medicine and Religion Program" was featured by the Academy of Medicine of Columbus and Franklin County on February 20. A reception hour and dinner preceded the meeting at the Imperial House North, in the northern area of Columbus. Special guests of the Academy were clergymen of Franklin County.

The topic "When Doctor and Pastor Meet" was discussed by Dr. Granger E. Westberg, professor of practical theology and director of continuing education at Hamma School of Theology, Wittenberg University, Springfield.

LUCAS

The Inter-Hospital Postgraduate Lecture Series on February 15 and 16 was presented by the Medical Advancement Trust of Maumee Valley Hospital and the Northwestern Ohio Heart Association. Guest speaker for the series was Dr. Victor A. McKusick, chief of the Division of Medical Genetics at Johns Hopkins University School of Medicine. Among topics discussed were: "Heritable Disorders of Connective Tissues," "Genetic Factors in Cardiovascular Disease," and "Genetics in the Practice of Medicine."

The March 13 meeting of the Academy of Medicine featured the Northwestern Ohio Institute for Continuing Medical Education Lecture Series. Speaker for the occasion was Dr. Calvin Kunin, professor and chairman of the Preventive Medicine Department, University of Virginia Medical School, whose topic was "The Rational Use of Antibiotics." Dr. Kunin also participated in medical rounds at Toledo Hospital and Riverside Hospital.

HAMILTON

A joint meeting of the Academy of Medicine of Cincinnati and the Cincinnati Bar Association was held on February 20 at the Netherland Hilton Hotel. A social hour and dinner preceded the meeting.

Speaker for the occasion was Oliver C. Schroeder, Jr., professor of law and director of the Law-Medicine Center, Case Western Reserve University, Cleveland.

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MAHONING

Dr. Herman K. Hellerstein, professor of medicine at Case Western Reserve University School of Medicine, was speaker for the February 20 meeting of the Mahoning County Medical Society in the Mural Room, Youngstown. A social hour and buffet dinner preceded the program. Dr. Hellerstein spoke on "Rehabilitation and Evaluation of Post Coronary Patients."

The Mahoning County Medical Society has launched a program among its members with the expectation that it will stimulate physicians to keep their affairs in order and help doctors and members of their families in cases of an emergency.

Two leaflets outlining Parts I and II of the program have been prepared. Part I is entitled "Arranging the Physician's Personal and Office Records," and contains an outline of some 34 points of record that the physician may wish to share with his family.

Part II is entitled "Closing the Physician's Office," and contains step-by-step actions that should be taken to help the physician retiring from practice, or to help the family in case of the doctor's death.

In the initial mailing to members, both leaflets were included. When a member of the Society dies, the second leaflet is mailed to the widow or other surviving next of kin.

TRUMBULL

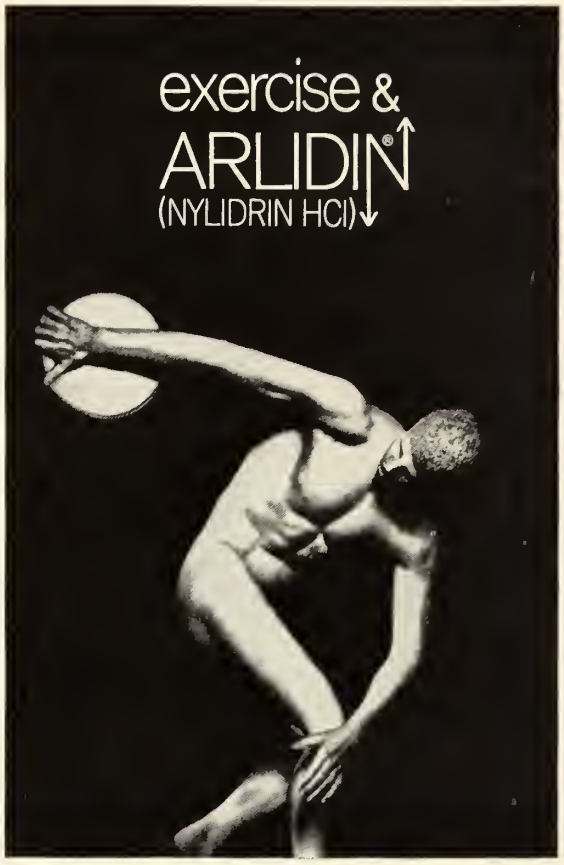
The regular meeting of the Trumbull County Medical Society was held on February 21 at the Hillside Hospital where dinner was served. Members of the Ministerial Association met with the Society and shared in a view of the Hillside program.

Wonderful World of Ohio Magazine -Is Interesting Publication

The Wonderful World of Ohio magazine is an interesting and picturesque publication and one that is playing a leading role in the extensive promotional program for the State.

Among features in a recent issue is an article on "beagling" and a notation that of 19 beagle packs recognized in the United States by the National Beagle Club, three are in Ohio. Another article describes a collection of captivating carnival glass made in the Ohio area. Still another feature describes the old time sugar house where maple sugar is processed, and so on. Articles are well written and illustrated in attractive four-color process.

Although promoted by the State, the publication must rely on support of Ohio citizens to continue its effectiveness. Physicians may wish to consider it as an addition to their waiting room publications or for the personal use of themselves and family. Subscription is $3.00 per year; $8.00 for three years; or $12.00 for five years. Address The Wonderful World of Ohio Magazine, 1500 Dublin Road, Columbus, Ohio 43212.



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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

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AN ORCHID for *Chatterbox* — the informative, interesting and scintillating publication of WA-SAMA (the Woman's Auxiliary to the Student American Medical Association). It has a rare individuality. These wives of interns and residents — OUR future members — are living proof of what a group of dedicated young women can accomplish. By helping each other, they of course help themselves. But even more important, they have started on the path to service for the medical profession.

There are 72 WA-SAMA chapters throughout the country. Not every county auxiliary can lend a hand in the way of services since obviously chapters are to be found only where there are interns and residents associated with university centers. But there's one way of helping so that these young doctors' wives can expand the group's many national programs and institute new ones: By becoming sustaining members of the organization — for a mere $5 annually. You can send your contribution directly to WA-SAMA, at 2635 Flossmoor Road, Flossmoor, Illinois 60422. To be such a sustaining member on the part of the established doctor's wife is a privilege. Would you like more detailed information on WA-SAMA? Write to our Ohio Auxiliary's liaison — Mrs. Joseph Tomashefski, 2071 Ellington Road, Columbus 43221. Peg will be delighted to tell you all about a remarkable organization and its remarkable young women.

Tidbits from National

There's a new, hard-hitting antismoking film, "A Time for Decision," recently released by the American Cancer Society. The 18-minute color cartoon produced by Hanna-Barbera (creator of TV's "The Flintstones") is aimed at community leaders around the nation. The film urges these leaders — clergymen, politicians, doctors, educators, parents, businessmen, and others — to become personally involved in the cigarette problem. Arrangements for showings of "A Time for Decision" may be made through any one of the American Cancer Society units.

Here's a wonderful idea for a particularly small auxiliary: all you need is five dollars for a mighty important community project: Two dollars will pay for 12 issues of *Today's Health* for your town library. Another two dollars will buy a subscription to the magazine for the school library. In both instances, a hand-signed gift card will tell the libraries that you are the sender. You still have a dollar left. This will buy six beautiful 12" by 16" watercolor landscapes painted expressly for *Today's Health* by a famous artist. These are on high-quality paper and suitable for framing. You may want to donate them to a school or library (or you may even want to keep them!). Now, of course, larger auxiliaries with considerably more than five dollars available can participate more heavily in this program too . . . (in fact, they should!). I'm told it takes about two minutes to send your order to *Today's Health,* American Medical Association, 535 N. Dearborn Street, Chicago 60610. Where else can you get so much for so little?

Medical societies, woman's auxiliaries and others concerned with health careers programming will find that *The Hospital People,* a new publication developed by the Blue Cross Association, is a useful, welcome addition to health careers literature. Published in color, the 84-page booklet traces the history of hospitals and calls attention to the complex problems confronting hospitals today, as well as highlighting rewarding career opportunities existing in hospitals. Approximately two-thirds of the booklet is devoted to 20 hospital-based careers, presented in narrative, on-the-job sequences. Copies of this valuable publication are available on a complimentary

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basis for health careers programming and other needs from any of the 76 local Blue Cross Plans.

Here and There

The January meeting of the Allen County Auxiliary featured two special programs, both aimed at community health needs. Mrs. Martin Sondheimer discussed the new Comprehensive Mental Health Center planned for the city. She illustrated her talk with a film "Crisis in Lima," sponsored and produced by the Lima and Allen County Mental Health Association. This was the first showing of the film. Venereal Disease was the subject discussed by Dr. Robert S. Oyer, Allen County Health Commissioner, and Mrs. William E. Noble. The emphasis was placed by both speakers on the need to educate adults and teens to the rising dangers of venereal disease. The special film "250,000 Teen-Agers" was also shown at this auxiliary meeting. Dr. Oyer commended the local group and Mrs. Noble who heads the project for making the film available at the Health Department for use to the public. He also complimented the doctors' wives for planning an educational program suitable for use in schools or for adult groups on request.

Mrs. L. W. Like, Allen County president, announced that Mrs. William G. Grannis was chosen as the "Most Typical Doctor's Wife." She will be entered in a state competition. This January meeting was in the form of a dessert luncheon at the home of Mrs. C. John Stechschulte. Hostesses included: Mr. Walter Beery, chairman; Mrs. A. Melvin Mulvania, Mrs. Asa Jones, Mrs. Grannis, Mrs. Roger Techlenberg and Mrs. Theophile Andjus.

"A Sketch of Living" was the program presented before the February meeting of the Allen County group at a luncheon in the Thunderbird Restaurant. Mr. Richard Clark, art director of the Lima City Schools was guest speaker, who said "I love art and could stay in an attic and paint forever, but that would be a selfish way of living . . . an even greater art is the art of living with people." Mrs. David Barr, chairman of the Disaster and Safety Committee, showed a film "One Who Cared" dealing with Red Cross work in the United States and in South Vietnam. Hostesses included: Mrs. Harold Lotzoff, chairman; Mrs. Joseph Oppenheim, Mrs. John Hubbell, Mrs. Clyde Conger, Mrs. Robert G. Hendershot, Mrs. Sylvia McGavern and Mrs. Robert Page.

Moving Around

The Butler County group cooperated recently with its medical society in a measles vaccination program. Nine members worked a four-hour shift at five local schools in Middletown. The special vaccination program was headed by Dr. John Perkins.

From Cuyahoga County's "From the Back Seat" (that highly entertaining newsletter) I glean these interesting bits of information: The health-careers scholarship program will get a boost in April from the group's annual Lilac Time Party which will be held at the Sheraton-Cleveland Hotel; local doctors' wives will model fashions from a well-known store; there are some spectacular gifts that will be raffled off. There was some mention in the *Journal*'s February issue of Cuyahoga's special Family Life Education program held at Higbee's in January. I should like to add that in addition to Mrs. W. Marlin Butts, the speaker mentioned in the earlier account, there was a talk by Dr. John J. Beeston, director, Cleveland Health Museum, who gave articulate support to Family Life Education and spoke of the importance of reaching parents. Dr. Thomas J. Barrett, obstetrician, St. Ann's Hospital, reported on Vatican II's progress in Christian education. All three major religious bodies (Catholic, Jewish, Protestant) have now taken affirmative steps, it was stated, to substitute Family Life Education for outdated taboos. On the Reactor Panel, Mrs. Alfred Jones, president of the Ohio Congress of Parents and Teachers, gave P-TA's support to the program. Mrs. Lelia Zamir, coordinator of Program in Mental and Physical Health, Cleveland College, discussed the evaluation of this highly important project.

"Food Parade"

Hamilton County has done it again! What else — but even more than a half-page spread in the

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February 28 issue of the *Cincinnati Post and Times-Star* . . . I really marvel at the tremendous newspaper coverage this auxiliary receives (I know I've commented on this before, but I cannot help but exclaim over this most unusual kind of newspaper cooperation because it's so doggone unusual!) This feature story was heralded "It's Hands Across the Buffet Table" and to be sure, it had a wonderful news twist because Hamilton's Food Parade had the benefit of doctors' wives from foreign countries whose husbands are in Cincinnati for advanced training. There were three each from the Philippines and India, two from Korea and one each from Poland, Colombia, Spain, Pakistan, Cuba, Canada, and England. To quote the comment of Fern Storer, the feature writer, "if the General Assembly of the United Nations could have a Food Parade occasionally, it might be a significant step forward in international relations" . . .

This special occasion was held in the Cincinnati Academy of Medicine Auditorium, with this year's "parade" based on an international theme with a good measure of favorites of this country sprinkled in. Mrs. W. P. Mazur is the group's chairman of International Hospitality and Mrs. Robert Gregory was hospitality chairman of the day. The newspaper story detailed a number of the recipes: Chicken Teri-Yaki as prepared by Nita Yamaguchi, Swedish Fruit Soup by Frances Krone, Frankfott Krantz (a cake) by Katy Hinrichs, Beer Cheese Dip by Helen Wiseman, and Male Cookies (the "come hither" name of some popular cookies made by Ann Ghory, daughter of auxiliary president, Mrs. Joseph E. Ghory.) There were many, many other delectable and unusual dishes, of course. What I have mentioned is just by way of a sampling!

In a recent special series on "Careers in Health" written by Margaret Weaver of the *Post and Times-Star,* the Hamilton auxiliary had a finger in that pie by hazarding suggestions and helping the author of the series to run down material, etc. One of the fine articles is devoted to Mrs. Paul Foldes, president-elect of the local group and this year's AMA-ERF chairman. Perhaps in another issue, I can devote a bit more space to this highly interesting and provocative series.

Still on "Meals"!

Lucas County came in recently for some fine publicity on its Meals On Wheels program. Of particular significance was the *Toledo Blade's* editorial (something newspapers seldom do, believe me!) Certainly I can appreciate the pride of the Lucas County gals upon reading the editorial's last line "It is difficult to imagine a more fitting public service contribution by women whose husbands are engaged daily in administering professionally to the general health needs of all" . . . nice going!

The group's February meeting was for the "Young At Heart." Young were the lovely grandmothers who were especially honored on this day and presented with corsages of pink carnations. All those present, I am told, felt singularly young as they listened to a sample of the music appreciation concerts given for the children of the Toledo Public Schools. Mrs. William Eggleston introduced the members of the Tolora Quartet who presented the delightful musical program. Hearts were all about in the beautiful Valentine decorations created by Shirley Stevens. Mrs. Henrikas Solys served as chairman of the luncheon, with Mrs. Antonia Muto as cochairman. Other members of the committee included: Mrs. Charles Petas, Mrs. Baltazar Reyes, Mrs. Joseph Garland, Mrs. Richard Johnson, Mrs. Harry Nicholson, Mrs. R. J. Wasylyshyn, Mrs. John Williams and Mrs. George Woods. Mrs. David P. Wheeler and Mrs. Burton S. Nelson, Jr., served as Happy Hour hostesses.

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525 North Fourth Street

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Article on Electric Shock Hazards Available from Heart Groups

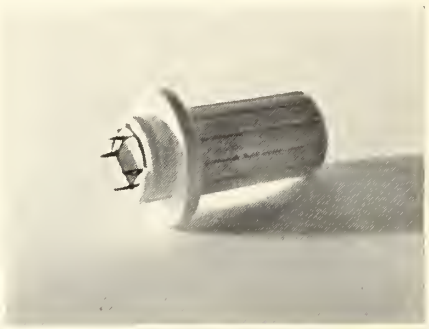
Some of the underlying principles governing the behavior of electrical equipment used in clinical cardiology, as well as certain dangers in conventional cardiological diagnostic and therapeutic procedures, are outlined in an article reprinted by the American Heart Association.

Entitled "Electric Shock Hazards in Clinical Cardiology," by Robert E. Wahlen, M. D., and C. Frank Starmer, the article discusses situations which are potentially dangerous in clinical cardiology. Included are cardiac pacing, catheterization, angiography, pericardiocentesis, and cardioversion. Safety precautions and equipment testing procedures are recommended by the authors. The article originally appeared in the AHA journal, *Modern Concepts of Cardiovascular Disease*.

Physicians, medical students, and hospital staffs may obtain copies of the reprint without charge from their local Heart Associations.

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Before prescribing Valium (diazepam), consult complete product information; a summary follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See **Precautions.**) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Y 1968
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The OHIO STATE MEDICAL Journal

Published By The Ohio State Medical Association

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BOSTON
17 MAY 1968

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VOL. 64 MAY, 1968 No. 5

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Address All Correspondence:
The Ohio State Medical Journal
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Columbus, Ohio 43215

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Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg every 6 hours for a minimum of 4 doses or 300 mg every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg every 6 hours or 300 mg every 12 hours until a cure is effected.

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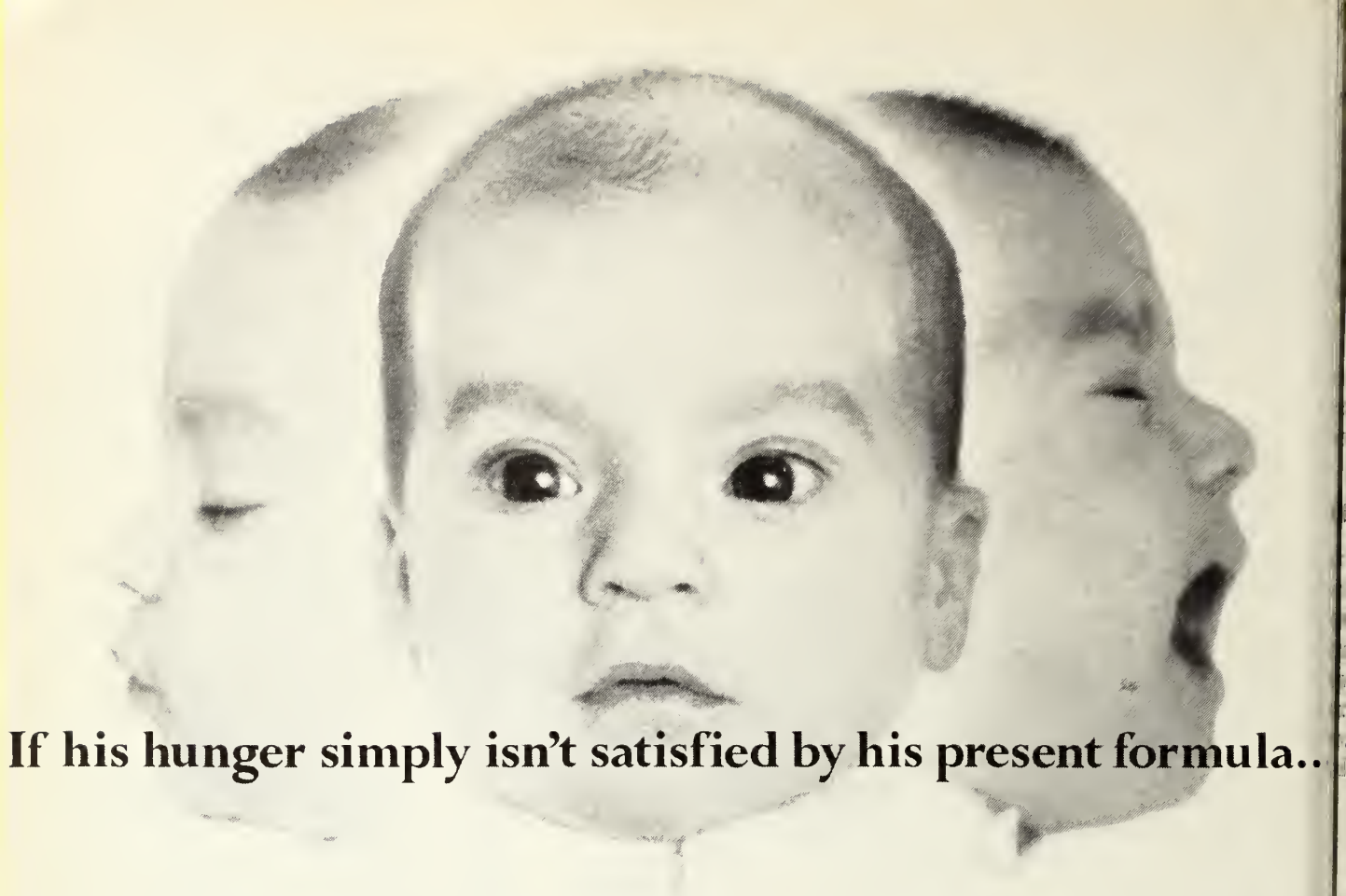


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Capric	2.2	1.1	1.5
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Myristic	6.3	5.1	5.5
Palmitic	10.2	16.2	14.0
Stearic	2.3	9.0	4.5
Unsaturated	**59.6**	**55.8**	**61.0**
Oleic	40.7	33.0	24.7
Linoleic	18.9	19.5	34.6
Linolenic	trace	2.3	1.7

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1. Hansen, A. E., et al: Pediatrics 31:171, 1963. 2. Holman, R. T.: Fed Proc. 23:1062, 1964. 3. Holman, R. T., et al.: Amer. J. Clin. Nutrition 14:70, 1964. 4. Hepner, R., et al.: Pediatrics 33:94, 1964. 5. Pikaar, N.A., and Fernandes, J.: Amer. J. Clin. Nutrition 19:194, 1966. 6. Hepner, R.: Current Therapeut. Research 9:140 (Suppl. 35) 1967. 7. Hart, L. M.: Ibid., p. 179. 8. Nichols, M. M.: Ibid., p. 184. 9. Young, R. J. and Garrett, R. L.: J. Nutrition 81:321, 1963.

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Two More Medical Students Will Be Aided by OSMA Scholarships

Two Ohio students entering medical school this year will each be awarded a $2,000 medical scholarship by Ohio State Medical Association. Administered by the Association's Committee on Rural Health, the scholarships pay each recipient $500 annually during his four years in the medical school of his choice. The award is paid directly to the recipient.

"These scholarships serve to encourage Ohio youths to enter the medical profession and to stimulate, among medical students, interest in practicing medicine in Ohio's nonmetropolitan areas," said Dr. Robert E. Howard, Cincinnati, OSMA President. He added that the scholarship program is in its twentieth year.

Dr. Howard explained that candidates must make application after they have been accepted by an accredited medical school, but prior to beginning their medical studies. Application forms may be obtained from OSMA at 17 South High Street, Columbus, Ohio 43215. Completed applications must be in the OSMA office no later than July 3, 1968. Applicants must be residents of Ohio, and are judged on the basis of integrity, interest in community activities and organizations, leadership, intelligence, maturity, and scholastic ability.

All applicants who have met the criteria for selection will meet with the Committee on Rural Health's Scholarship Committee on Wednesday, July 10, at 10:00 A. M., at the Fort Hayes Hotel in Columbus. Following interviews, luncheon will be served. The committee will then meet to choose the two winners.

Winners of the 1967 scholarships were Alan T. Tong, of McComb (Hancock County), and William H. Kose, of Pickerington (Fairfield County). Both Tong and Kose are currently freshmen in the Ohio State University College of Medicine.

Members of this year's Scholarship Committee are Luther W. High, M. D., chairman, Millersburg; Walter A. Campbell, M. D., Coshocton; E. D. Mattmiller, M. D., Athens; and Leonard S. Pritchard, M. D., Columbiana.

Regulations for Motorcycle Safety Under New Law Are Announced

Official regulations for head and eye protection of motorcycle operators and passengers have been established effective April 3 and registered with the Secretary of State, as required by the Revised Code of Ohio.

Authority stems from House Bill 380, enacted by the 107th General Assembly, and signed into law by Governor James A. Rhodes.

The regulations deal with the wearing of head protection and eye protection by both operator and passenger, and other safety measures.

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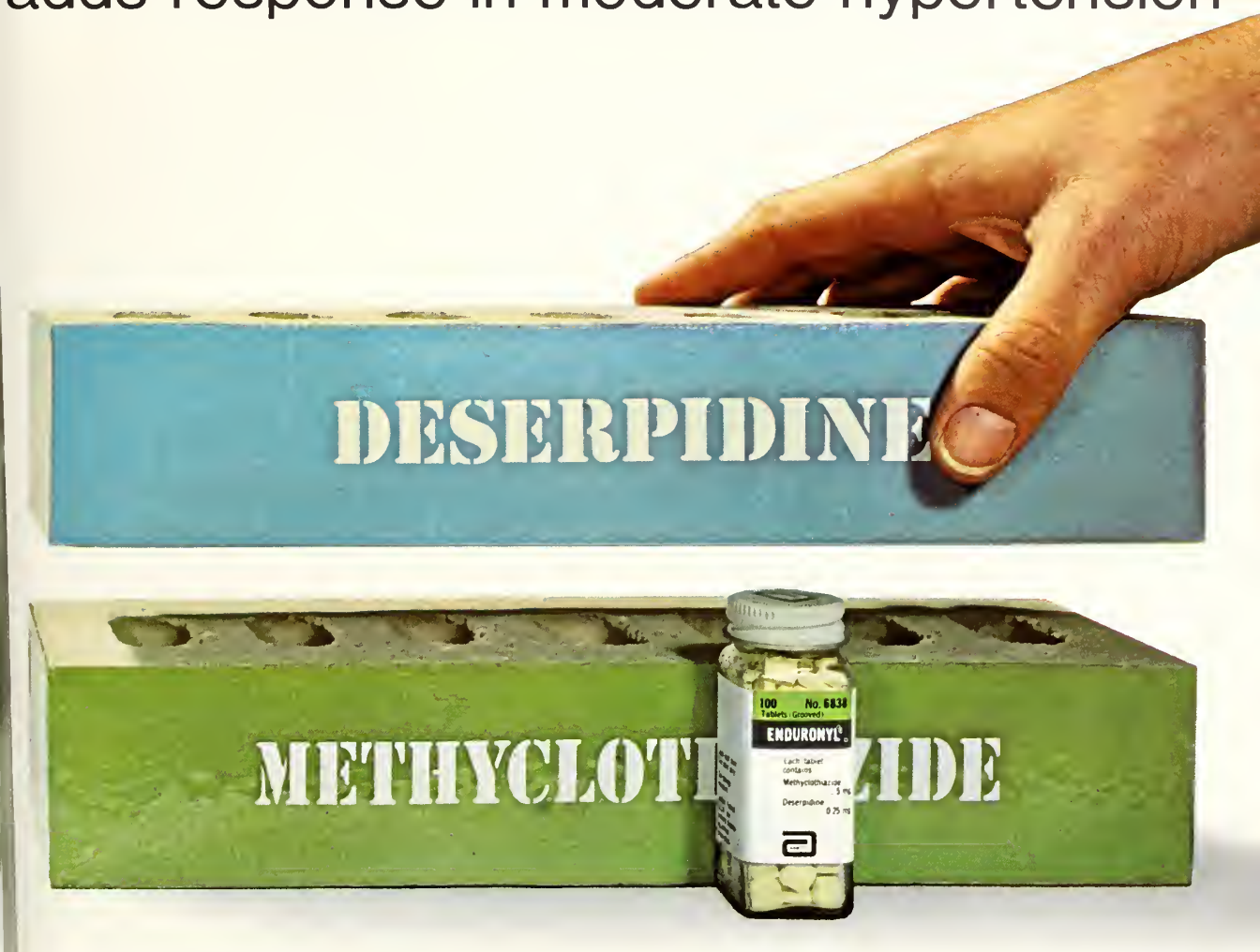
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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug.

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TM-TRADEMARK

The Silver Bridge Disaster

By OSCAR W. CLARKE, M. D., Gallipolis, Ohio

FRIDAY, DECEMBER 15, 1967, in this Southeastern Ohio area, was an overcast bone-chilling day. However, with the exception of the pre-Christmas rush, there appeared to be nothing unusual about the day. Suddenly at 4:45 P. M., the whole world changed for the inhabitants of the Gallipolis, Ohio, and Point Pleasant, West Virginia, area. The Silver Bridge, spanning the Ohio River, collapsed.

The Silver Bridge was a main artery and lifeline of the two communities of Gallipolis and Point Pleasant. It has been described as the Silver Bridge, the Gateway to the South, and a monster of Beauty. It was an aging beauty, for construction of the bridge was started in May, 1927, and it was opened for traffic on May 19, 1928.

The Silver Bridge was the first bridge of its particular type of construction in America. It was a pioneering architectural design, for it used heat-treated "eye-bar" chains for suspension. This differed in the respect that most wide-span bridges use multiple, interwoven wire cable for suspension.

The bridge was painted with a bright aluminum paint; and since it was the first bridge in the area to adopt this particular type of coating, it was quickly given the name "Silver Bridge" and was quite beautiful to view. The bridge was approximately 2,230 feet long, and had an anchorage of 200 feet on each side of the river which was the foundation for the suspension chains. The suspension portion of the structure consisted of two giant girder spans of 340 feet, and it had a channel span of 700 feet. The span was estimated to be approximately 100 feet above the low water gauge on the river. Its roadway was 22 feet wide, and it had a sidewalk on one side 5 feet in width.

The unusual 24 "eye-bar" hangers were constructed each 2x12 inches and were from 25 to 30 feet long. These "eye-bars" were especially heat-treated bars and were of a high quality steel having a tensil strength of approximately 55,000 pounds per square inch.

The steel towers above the piers were raised to a height of 190 feet above the pool stage of the river. The flooring of the bridge was grill steel covered with concrete.

The general attitude of the natives concerning the bridge was that it was old, and it was definitely known that it had a "flutter problem." Also, the "bounce" one felt when waiting on the bridge for the traffic to clear was considered to be increasing as the years passed, but no one accepted this as any threat of danger. However, there was a short warning which was not interpreted as such just prior to the collapse of the bridge. It has been reported by the United Press International that a broken bar had been found, an observation which has developed into a vital point of attention by Federal investigators, under whose instruction the collapsed bridge is being completely reassembled for study.

Eye-Witness Reports

The eye-bar reportedly was in the chain between the Ohio shore and the Ohio bridge tower on the upriver side. It was reported by many eye-witnesses that the bridge started to fall in this vicinity. However, this fact has never been proven. The United Press stated that the bar was broken clean at the eyelet, that part of the bar with a doughnut-like hole where it connected to another bar in the suspension chain. Left bolted to another eye-bar, was a half-moon shaped piece of steel.

At the middle of the broken piece was a crack three to four inches long. The bar was from the same, general vicinity where two people saw or heard the early warnings within 30 minutes of the disaster. The United Press stated that no one knows, or no one would speculate whether the three facts were connected with the bridge's collapse. However, Mrs. Earl Henry, Jr., of Point Pleasant, was crossing the bridge at 4:30 P. M. when she heard a "clanking noise" as she passed the Ohio tower toward Kanauga, Ohio. She stated that she had never heard this particular sound before, and she looked around to see what it was. She said she felt as if it were something metal loose on the bridge and maybe the wind was blowing it against the bridge, or something was striking it.

About five minutes after this, Mr. Floyd Forbus, of Point Pleasant, was returning home from work

A practicing physician in the Gallipolis area, Dr. Clarke is a diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, and a member of the American Society of Internal Medicine. He is a member of The Council of the Ohio State Medical Association, representing the Ninth Councilor District.



The Silver Bridge, so called because it was the first in the vicinity to bear a coat of aluminum paint, served as the Gateway to the South since its opening in 1928. It had otherwise been designated "a monster of beauty."

at Kanauga; and as he neared the Ohio tower, he saw a large nut on the roadway. It was about a two-inch nut. He reported as follows: "When I first saw it, I thought it could be off the bridge. Then I said to myself, no, it's not big enough. Then after the bridge had collapsed, several days later, I went to the piers on the West Virginia side and looked at the nuts on the plates which cover the eye-bar connections. I am pretty sure it's the same kind of nut."

Whether these were a few last minute warnings are not known at this time. However, many had their fears concerning the Silver Bridge.

It has been fairly well established at the present time that there were 35 vehicles on the bridge when it collapsed.

Most of the load, 22 of the vehicles, were passenger cars, and five trucks were concentrated on the Ohio side of the bridge in the westbound lane. Six passenger vehicles and two trucks were eastbound toward West Virginia in the middle of the span.

Of this total, 11 fell on dry land on the Ohio side when the bridge collapsed, 23 were recovered from the river bottom, and one vehicle is still missing.

At the time of this writing, 42 bodies had been claimed and four bodies were still known to be missing.

Disaster Planning Pays Off

Within five minutes of the collapse of the bridge, all three hospitals in the area were aware of the disaster. Thanks to previous disaster planning which had been started several years ago and instituted by the Mid-Ohio Valley Industrial Emergency Planning Council, the emergency vehicles in the West Virginia and Ohio area had a predetermined plan of ambulance and emergency vehicle evacuation and concentration.

On the West Virginia side, the Pleasant Valley Hospital received its call of notification at 5 P. M. from a telephone operator simply stating the foregoing facts. However, the facts were so unbelievable that the hospital administrator immediately called a business concern located near the bridge for confirmation. The Pleasant Valley Hospital's disaster plan was immediately put into effect. Two physicians present in the hospital at the time were requested to stand by. The business manager, using a private line not connected with the main switchboard, notified department heads, calling the chief of nurse first. Meantime, personnel on duty made ready to receive casualties, utilizing all available space in the Emergency and outpatient area. Mattresses were brought from a store room and placed in available floor space in the hallways and corridors.

The Chief Nurse arrived at the hospital at 5:10 P. M. and helped to coordinate activities. Then, the third doctor on the staff of Pleasant Valley Hospital reported to the hospital. The fourth doctor reported five minutes later.

An auxiliary volunteer was placed at the entrance to the hospital for the purpose of furnishing in-

formation and for controlling visitors and curiosity seekers.

One office girl was placed at a phone station to handle incoming calls from the public and press in order to keep the switchboard clear.

Patients Are Given the Facts

The Pleasant Valley Hospital at this time was crowded and was carrying a capacity load of patients and was also in the midst of an expansion program with construction items around the hospital grounds and on the hospital premises. It was practically impossible to keep the inpatient personnel from being aware of the disaster and since the patient halls were being used as temporary front entrances, there was an announcement made on the hospital intercom for all patients and patients' visitors to remain in the patients' rooms until the area could be cleared. Full cooperation was received from all.

The operating suite and emergency supplies, drugs, oxygen, and plasma were made available with the personnel stationed to handle these items. Disaster tags were made ready by clerical help, which had been assigned to this task.

A line of communication was set up from the Emergency Room to the switchboard and volunteers were instructed to keep everyone out of the area except personnel reporting for duty and members of the immediate disaster team.

The first patients arrived at 5:25 P. M. Only five patients were received at the Pleasant Valley Hospital. A physician was at the door when each ambulance arrived and acted as medical coordinator for these cases.

Many of the hospital personnel reported to their work stations without being called. This did not create a major problem as the situation was controlled, and there was no evidence of panic. These people were available if needed. They had practiced drills and were familiar with their disaster stations.

The dietary department remained open and fully staffed.

By the time, the first patients arrived, Pleasant Valley was fully staffed and ready to handle the situation.

Identification cards for hospital disaster personnel were issued to members of the disaster team at the time of their employment and were on their persons for immediate need. Possession of ID cards assisted many of the personnel in getting through the police control system on their way to the hospital.

A traffic problem developed at the entrance to the hospital. However, this was immediately cleared by volunteer hospital staff who became traffic directors. Five patients were admitted. One had sustained a fractured humerus and was in a mild state of shock. The second patient had sustained fracture of three vertebrae and also was in a state of shock. The third patient had suffered the fracture of two vertebrae and was in moderate shock. The fourth patient had no lacerations or fractures, but was in moderate shock from exposure and immersion and was released from the hospital after several hours of observation. The fifth patient, likewise, was suffering from immersion and exposure, and was kept for a 24-hour period.

Mrs. Kathleen C. Marnhout, R. N., administrator of the Pleasant Valley Hospital, praised the staff for its excellent performance. The major factor of her critique was that an improved method of reaching department heads would have to be devised, probably by supplying the central operator at the municipal exchange with a list of key department heads, which should be called if a disaster alert was instituted.

Gallipolis Hospitals

In Gallipolis, Ohio, there are two hospitals, the Holzer Hospital, and the Medical Center Hospital. The Holzer Hospital personnel were aware of the disaster within five minutes after the collapse of the bridge and immediately instituted their disaster plan. At the time of the disaster, a number of physician staff members were completing their work-day and were in the hospital at the time. Attempts to call back the remainder of the staff were instituted. However, at this time, Gallipolis suffered a collapse of telephone service for the city. This breakdown was created by the sudden load upon the exchange of many phones being operated simultaneously. In addition there was a sudden tremendous load of incoming calls from outside the area. This same phenomena was noticed in Washington, D. C., immediately following the news of the assassination of President Kennedy, and the city was without adequate phone service for several hours. The telephone service in Gallipolis was back in partial operating condition within approximately 45 minutes to an hour after its first failure. In spite of the inabilities to use the public telephone system, the Holzer Hospital disaster plan had been so well planned that it functioned without direct contact with members of the disaster team.

Donald M. Thaler, M. D., staff member of Holzer Hospital, and chairman of the Southeastern Ohio Region Committee on Trauma of the American College of Surgeons, reported that the disaster plan was put into effect immediately on the ground floor of the hospital and all parking was restricted to visitors and doctors parking lot, to allow for a free entrance of emergency vehicles. All necessary emergency equipment — stretchers, intravenous equipment, etc. — was available in the disaster area and was immediately staffed by doctors who were in the hospital at the time of notification. As soon as



This is an aerial view of disaster site shortly after the mighty span collapsed into the Ohio River. The railroad bridge is shown at the left.

news of the disaster became available, regular duty hospital personnel who had either just left the hospital or were off duty, reported to the hospital of their own free will and were assigned to various stations. Dr. Thaler stated that the disaster plan and equipment was operational within 25 to 30 minutes from the first moment of notification.

The first two patients arrived at Holzer Hospital at 5:15 P. M., approximately 15 minutes after the disaster. These were two truck drivers, one of which had an extensive laceration of the scalp and face, and the other was a patient who had a fracture of the lumbar vertebrae and a fracture of the right pubic rami and lacerations of the face and scalp. These people were quickly evaluated and passed through the receiving disaster area to the second floor emergency room where further evaluation was carried out by members of the staff. During this time, Dr. Thaler reported that futher mobilization of the disaster plan was being completed. This procedure consisted of shifting patients within the hospital to make rooms available for anticipated disaster victims. The dietary department immediately began preparing food in the form of coffee, sandwiches, and so forth, to feed the staff, victims, relatives, and rescue workers.

Results of Planning

Dr. Thaler further stated that the disaster plan resulted in the following provisions and procedures.

First, facilities for receiving injured persons were ready with free access from emergency vehicles.

(2) An immediate disaster area was set up, equipped and staffed, and ready for handling victims as they arrived in the door.

(3) Within the hospital, inpatients had been shifted to make room available for actual victims.

(4) Operating personnel had one operating room ready with one surgical team fully manned. Second, third, and fourth operating rooms were in the process of preparation.

(5) Laboratory personnel were ready. Approximately 30 units of blood were on hand. Eighteen units of frozen plasma were starting to thaw. A



This close-up view of vehicles entwined in mangled steel gives only a partial picture of total disaster. The search for victims continues in the background.

Is it depression?

He says "It's my stomach..."



...but his other symptoms:

functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt

strongly suggest an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl
AMITRIPTYLINE HCl

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

blood donors station was available for drawing additional blood. In excess of 100 units of frozen plasma was available within the hospital and IV teams were ready with the IV set ups.

(6) The dietary department was preparing food and ready for runner service.

(7) Hospital administration was manning information service, ready to aid in the identification and admission of disaster victims.

(8) Morgue set up instituted at the Methodist Church, across the street from the hospital.

(9) An information center for relatives was established at the Episcopal Church located next door to the hospital. Appropriate individuals were stationed around the hospital to direct the public.

(10) There were 21 doctors on duty. This was within 35 minutes from the time of the first notice of disaster.

Four victims, dead on arrival, were transported from the hospital entrance area and taken to the temporary morgue, and four patients were admitted to the hospital by 7:40 P. M., and only one of these, with lacerations, was taken to surgery. By 7:30 P. M., it was evident to the staff at Holzer Hospital that additional victims were not going to be received, and the personnel were dispersed.

Previous Emergency Experience

The Medical Center Hospital in Gallipolis, Ohio, which is a small 25-bed unit had been classified by the Mid-Ohio Valley Industrial Emergency Planning Council as a receiving hospital for only Class I emergency disaster type patients. The Medical Center Hospital received word at approximately 4:55 P. M. At that time four physicians were in the hospital and activated their disaster stations. One other physician arrived approximately 20 minutes after the disaster call, and the sixth physician telephoned to see if he were needed. The Medical Center Hospital had a full emergency run in July, of 1967, when suddenly it received 14 patients from an industrial accident in the area, and due to this experience, all the staff were well posted and ready to receive patients. However, very early it became obvious that the Silver Bridge would not produce additional disaster patients, but would produce fatalities, and standby facilities would not be needed. There were no patients received at the Medical Center Hospital from the Silver Bridge disaster.

An account of the Silver Bridge disaster would not be complete without particular notice going to Mr. Paul Wagner and the staff of the Radio Station WJEH, of Gallipolis, Ohio. When the phone system in the city failed, Mr. Wagner's staff being strategically located both at the scene of the disaster and on the West Virginia side of the river, kept the area closely informed of all developments as rapidly as they could be observed. Officials on the scene gave spot interviews and descriptions of the work being done, in fact, for a while this was the only open means of communication between the three hospitals and the scene of the disaster.

Importance of Communication

This experience definitely points up one of the major weak points in all of the recent medical disasters, and that is, the potential failure of communication. All have become accustomed to immediate use of the public phone system. There is little concept of the sense of frustration and isolation that develops when the phone system is over-burdened and cannot function properly.

It is the general consensus in this area that all medical facilities should as rapidly as possible provide some type of citizen's band radio communications with the emergency vehicles in the area, with the police authorities in the area, and with all key public personnel who would be needed in the time of a medical disaster.

For some reason, there seems to be reluctance on the part of many medical institutions to take advantages of advances in civilian band radio facilities, especially in view of the relative inexpensive nature of this equipment.

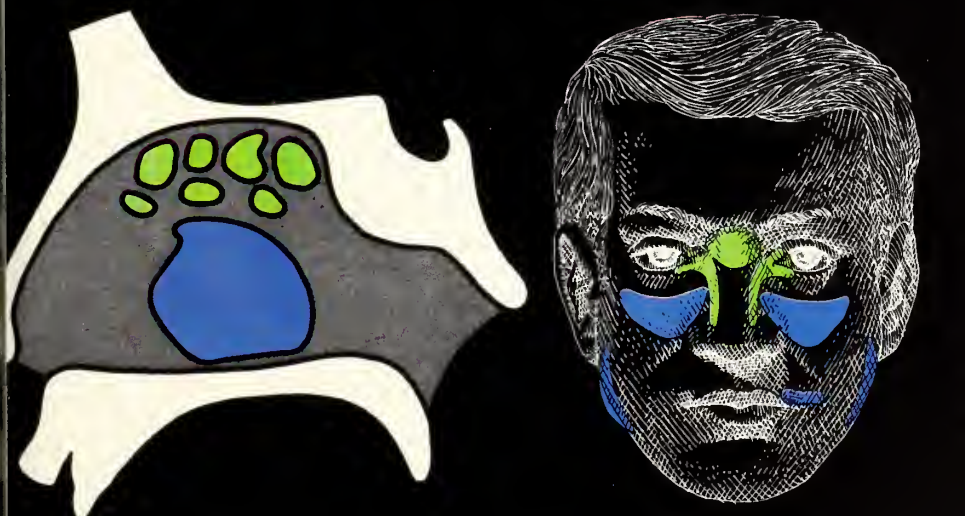
Also the importance of walkie-talkie communication within the hospital itself should be stressed, such units being assigned to key posts for use when the usual routes of communication are not open. It is the impression of this observer that it well behooves every hospital administrator and chief of staff in Ohio to immediately investigate the institution of an adequate communication system both within and without the hospital for use at times of grave emergency when usual lines of communication may not be available.

Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB



Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q.* 4 *h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

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Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

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•**SEDAFAX** (brand of special micronized grade of AMOBARBITAL - Warning: may be habit forming).....**120 mg.**

•**DELFETAMINE** (brand of dl-N-METHYL-AMPHETAMINE HCl).....**30 mg.**

Usual Adult Dosage: **One tablet daily. To be taken in the morning.**

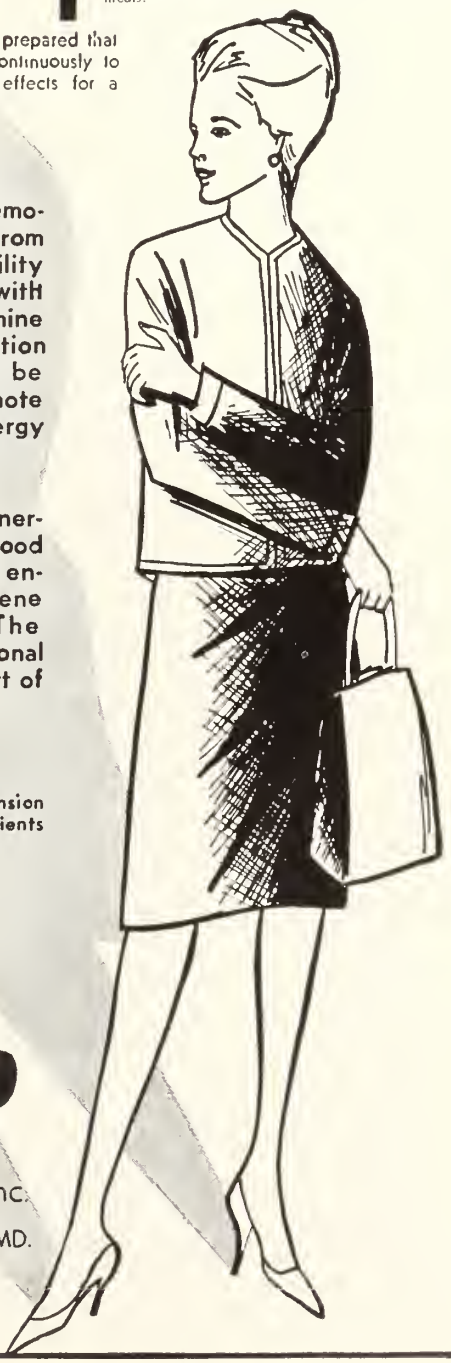
Tablets Delfeta-sed* ®

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•**DELFETAMINE** (brand of dl-N-METHYL-AMPHETAMINE HCl.).....**10 mg.**

Usual Adult Dosage: In obesity, 1 tablet t. i. d. 30-60 minutes before meals. In all other conditions, take 1 tablet t. i. d. immediately after meals.

†**STEDYTABS DELFETA-SED** are so prepared that the active ingredients are released continuously to provide for prolonged therapeutic effects for a period of up to 8 to 10 hours.



The dieting obese sometime experience emotional problems as secondary symptoms resulting from restricted food intake: anxiety, depression, irritability and tension. Subjective relief is accomplished with Delfeta-sed (Delfetamine, dl-N-Methylamphetamine HCl) balanced with the mild euphoric sedative action of Sedafax, brand of Amobarbital-Warning: may be habit forming). The mood is altered to promote optimism and impart a cheerful sense of energy and well-being.

IN DEPRESSION: A completely logical synergistic combination of wide application as a mood normalizer for the common depressed states encountered in everyday practice. Induces a serene outlook without excessive tranquillity. The patient is alert but composed, free from emotional peaks and troughs. Relieves anxiety which is a part of every illness.

CAUTION:

Contraindicated in the presence of marked hypertension and in cases of coronary or cardiovascular disease; also, in patients hypersensitive to Barbiturates or ephedrine-like drugs.

TOMORROW'S THERAPY TODAY
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County Maternal Health Survey Marks Its 20th Anniversary

The Columbus Obstetric-Gynecologic Society will celebrate two decades of a continuous, Franklin County Maternal Mortality Study, at its regular meeting, Wednesday, May 29, at 8:00 P. M., in the University Club of Columbus.

Founded in 1948 by Drs. R. L. Meiling and Anthony Ruppersberg, Jr., the study has operated continuously as a scientific research project aimed at reducing deaths among pregnant women and their infants.

Each year, at its final meeting, the Columbus Obstetric-Gynecologic Society sits as a committee of the whole, to evaluate and discuss each case presented, then to classify the cause of death and avoidable factors. Anonimity is preserved.

Members of the committee are: Drs. Joseph M. Gallen, John Douglas Veach, Robert A. Heilman, Richard L. Meiling, and Anthony Ruppersberg, Jr., chairman.

This survey is a cooperative effort of the same Committees for the Academy of Medicine of Columbus and Franklin County in coordination with the similar Committee of the Ohio State Medical Association, for "Maternal Health in Ohio."

Physicians, especially those interested in obstetrics, are invited to attend the conference.

Increasing Cost Factors Reported In Extensive Hospital Survey

The cost to the nation's community hospitals to provide one patient with a day of care rose to an average of $58.06 in 1967, the American Hospital Association reported in the March 16 issue of *Hospitals,* Journal of the AHA.

The figure represents a 15.4 per cent increase over the 1966 average expense of $50.31 per patient day, according to Hospital Indicators, a monthly report published in *Hospitals.*

The Indicators are based on data from a sample of 656 hospitals selected from a universe of 5,812 short-term general and special hospitals registered by AHA.

The $58.06 represents average daily expenses to the hospitals for payroll, equipment, services, supplies, and employee fringe benefits.

A 17.4 per cent increase in payroll expense per patient day was among the factors contributing to the overall increase in expenses, according to Hospital Indicators.

Wages and salaries accounted for $36.30 of the per patient day expense in 1967, or $5.38 more than the $30.92 required in 1966. Inclusion of hospital employees under federal minimum wage and over-

time pay laws and higher salaries paid to nurses and other paramedical personnel contributed to the higher payroll costs.

The nation's 5,812 community hospitals incurred total expenses of $12.6 billion for both inpatients and outpatients in 1967. That is $2.1 billion more than the $10.5 billion in 1966 expenses.

Increased utilization of hospital facilities played a part in the hospitals' total increased expenses, Hospital Indicators said. For example, total admissions to community hospitals were up nearly one per cent in 1967 over 1966, and the average daily census increased 4.2 per cent in the past year.

In addition, the length of patient stay increased from 7.7 days per admission in 1966 to 8.0 in 1967, and the number of outpatient visits jumped by seven per cent during the year. The occupancy rate was also up in 1967 — from 77 per cent to 78.1 per cent.

The impact of Medicare upon hospital utilization by persons 65 and over is reflected in the 5.1 per cent increase in the over-65 admissions reported in the last six months of 1967 over the same six months of 1966. The Medicare program began July 1, 1966.

The number of births in hospitals continued to decline in 1967. There were a reported 3.2 million births, a decrease of 1.5 per cent from 1966.

Fulltime hospital employees increased again in 1967, according to Hospital Indicators. In 1946, there were 148 fulltime employees for every 100 patients, but in 1967 that ratio had risen to 264 employees per 100 patients.

Two Ohio Medical Students Receive Foreign Travel Fellowships

Thirty-one junior and senior U. S. medical students have been awarded Foreign Fellowships which will enable them to obtain supervised medical experience in developing areas of the world, the Association of American Medical Colleges announced.

The Fellowships are made possible by a grant from Smith Kline & French Laboratories. With the current selection, the Association, during nine years, has awarded a total of 277 Fellowships for work and study in more than 50 countries of Africa, Asia, Latin America, and Oceania.

The primary objective of the Fellowships is to provide students with an opportunity to benefit from unusual clinical experiences and familiarize themselves with medical, cultural, and social problems different from their own. They will be stationed in mission hospitals and outpost medical facilities.

Ohio students are Marjorie Alma Harelick, Columbus, Ohio State University College of Medicine, whose site of fellowship is Friends Hospital, Kaimosi, Kenya; and Alice Katherine Maynard, Cleveland, Case Western Reserve University School of Medicine, assigned to American Hospital, Gaziantep, Turkey.

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 yea of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis i schizophrenics and agitation (includ-

When a milestone in life is marred by depression...



Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by depression with such symptoms as feelings of sadness, incapacity, helplessness and hopelessness.

Tofrānil often relieves symptoms of depression.

As maintenance therapy during the active phase of depression, it may help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; or in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication, or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy, the special precautions listed in the prescribing information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the full prescribing information.

ng hypomanic and manic episodes) vhich may require dosage reduction and/or addition of a tranquilizer or emporary discontinuation of the drug, epileptiform seizures, orthostatic ypotension and substantial blood pressure fall in hypertensive patients, urpura, transient jaundice, bone marow depression including agranulocytosis, sensitization and skin rash ncluding photosensitization, eosinophilia, and mild withdrawal symptoms n sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in usceptible patients and in those sing anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 5 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6522R

An anorectic will help her lose weight–
but can she keep it off?
You need more than a pill
(even ours) to do that!



That's why Abbott offers you a pill plus a program.

ABBOTT

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their calorie content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444



Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

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New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during March. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Belmont
Reeder, Paul, A., Jr., Barnesville

Butler
Alvarez, Frank M., Hamilton

Cuyahoga
Albert, David J., Cleveland
Angeles, Jaime S., Cleveland
Ansari, Amir H., Cleveland
Armentrout, Steven A., Cleveland
Avendano, Virgilio A., Cleveland
Boutouras, George D., Cleveland
Ciemins, Vilnis A., Cleveland
Coffin, Laurence H., Cleveland
Ferrer, Bonifacio H., Cleveland
Fleming, James E., Cleveland
Geurkink, Nathan A., Cleveland
Gold, Eli, Cleveland
Gomez, Francisco D., Cleveland
Gottlieb, Marvin E., Cleveland
Jaramillo, Jaime, Cleveland
Kastelic, Joseph E., Cleveland
Lester, Harvey A., Cleveland
Liu, Wai To, Cleveland
MacLean, Bruce F., Cleveland
Mata, Antonio S., Cleveland
Michael, Michael A., Cleveland
Miller, David G., Cleveland
Nichols, James F., Cleveland
Rees, June M., Cleveland
Sawczyk, Josephine, Cleveland
Schwartz, Richard A., Cleveland
Wieland, Ralph G., Jr., Cleveland

Franklin
Barnes, Francis E., Columbus
Batley, Frank, Columbus
Blazek, James V., Worthington
Coddington, R. Dean, Columbus
Davidson, Horace B., Jr., Columbus
Gresham, Glen E., Columbus
Keller, Martin D., Columbus
MacLean, Ian C., Columbus
Miglets, Andrew W., Jr. Columbus
Morton, Lawrence E., Dublin
Oktener, Haldun H., Columbus
Pangalangan, Augusto L., Columbus
Perrine, George A., Jr., Westerville
Schulte, John H., Columbus
Shuttleworth, Edwin C., Columbus
Stetson, John B., Columbus
Stockum, Alfred E., Columbus
Tzagournis, Manuel, Columbus
Vaughn, Charles R., Columbus
VerMeulen, Victor R., Columbus

Greene
Bolton, Barrett H., Yellow Springs
Rahimudden, Mohamed, Yellow Springs

Hamilton
Alamin, Khosrow, Cincinnati
Considine, Basil, Jr., Cincinnati
Fidler, James P., Cincinnati
Gross, Charles W., Cincinnati
Kreyling, George H., Cincinnati
Nascimento, Carmosino C. Do, Cincinnati

Knox
Thomas, Myron E., Mt. Vernon

Lake
Rix, Francoise H., Cleveland

Lorain
Moon, Tong W., Lorain

Lucas
Cygnor, Ronald J., Toledo
Frogameni, Anthony D., Toledo
Ganthier, Rulx, Toledo
Hauman, Robert L., Toledo
Munoz, Jose A., Toledo
Sido, Robert L., Waterville

Mahoning
Gilliland, Robert L., Youngstown
Klahr, Betty J., Youngstown
Kopinski, Joseph C., Youngstown
McGowen, Charles H., Youngstown

Montgomery
Brenner, L. Peter, Dayton
Dodson, Verne H., Miamisburg
Edmondson, Alan L., Dayton
Jenkins, Richard G., Jackson Center
Kalnins, Aivar I., Dayton
Molfenter, Gerald A., Dayton
Moyes, Martin K., Dayton
Sawvell, Austin R., Dayton
Segar, Ronald J., Dayton
Weis, Edmund B., Jr., Dayton
Winslow, Robert C., Dayton

Pickaway
Carpenter, Clarence J., Orient

Summit
Karapashev, Naum N., Akron
Roszell, Leo H., Akron

Tuscarawas
Navarro, Ignacio, Dover

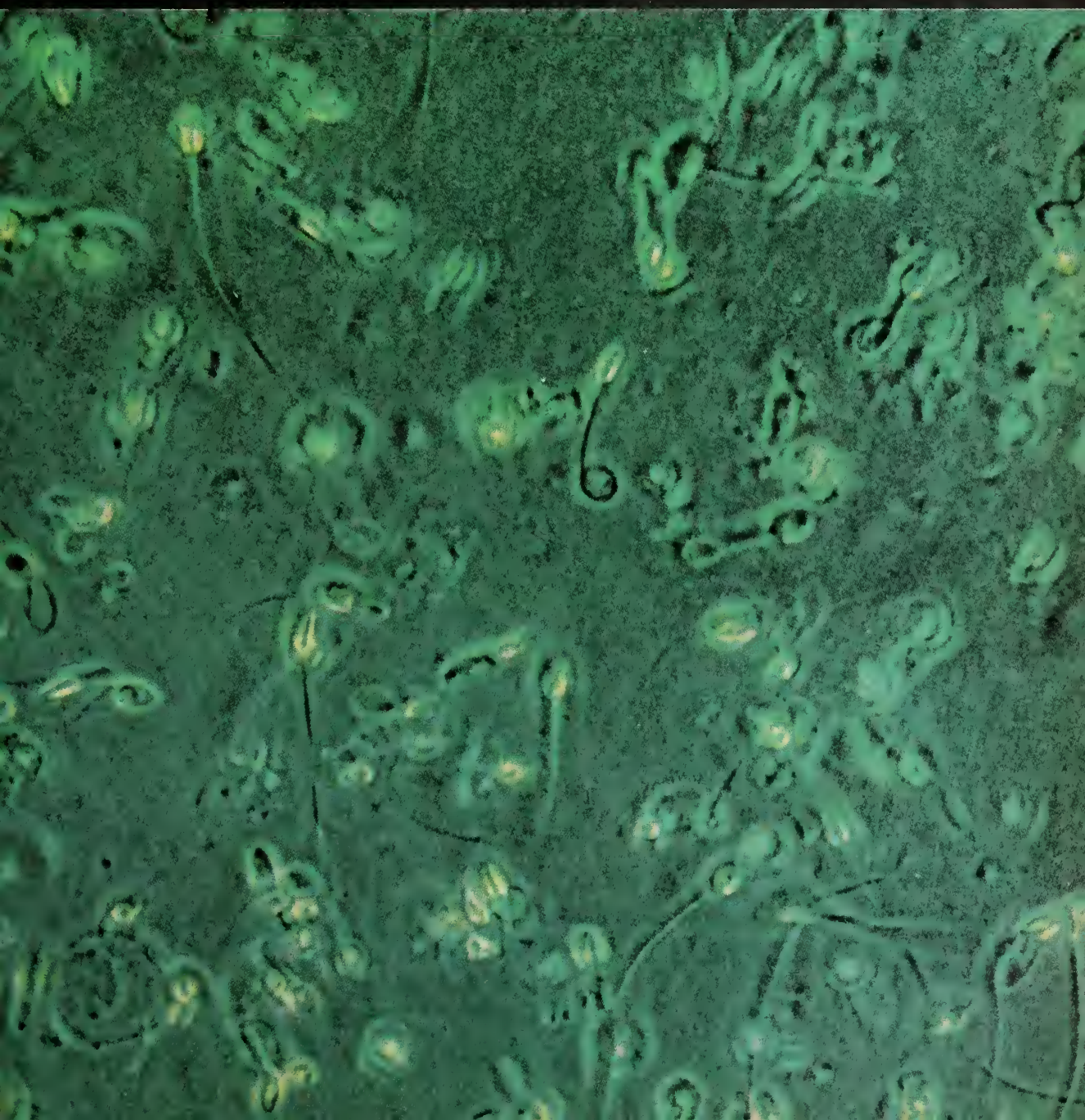
Children's Hospital of Columbus Reports Activities for 1967

Children's Hospital, Columbus, in its 1967 Annual Review reported the following summary of activities: Admissions, 14,091; patient days, 86,954; average daily census, 238; average length of stay, 6.1 days; outpatient visits, 77,442; emergency room visits, 35,194; Ohio counties served, 83; unpaid care, $651,000; hours of volunteer service, 26,712.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg ē mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weig (increase or decrease), changes in cervical erosion and cervical secretio suppression of lactation when giver immediately postpartum, cholestati jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, chang in libido, changes in appetite, cystiti like syndrome, headache, nervousn dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema noc sum, hemorrhagic eruption, itchin

The following occurrences have bee observed in users of oral contraceptives (a cause and effect relationshi has been neither established nor di proved): thrombophlebitis, pulmon embolism, neuro-ocular lesions.

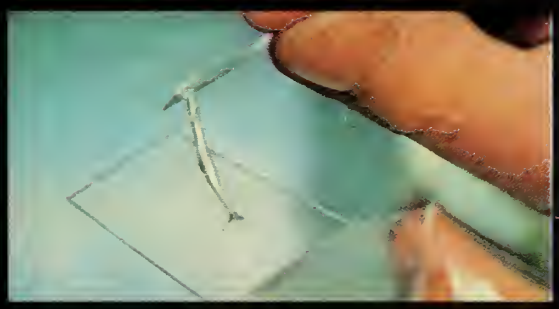
The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine a decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

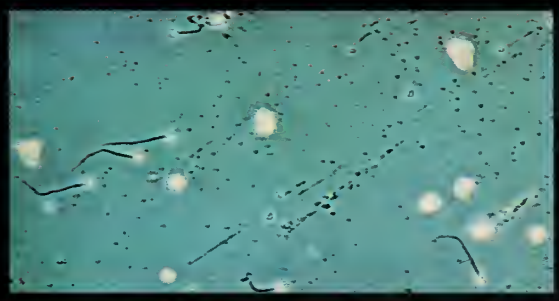
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

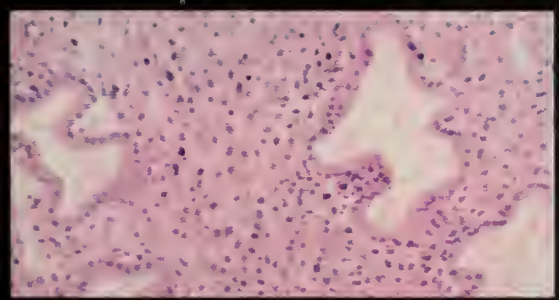
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

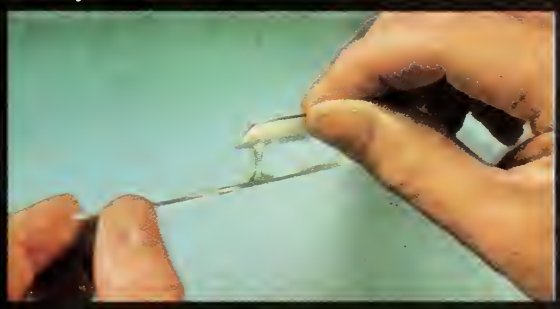


Spermatozoa appear healthy, active, freemoving.

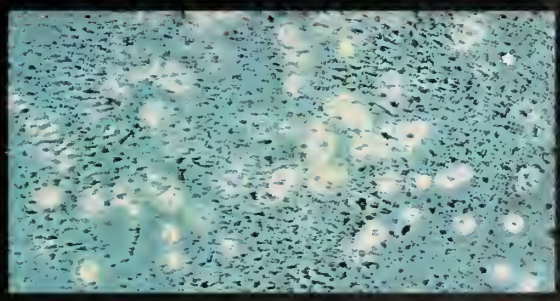


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

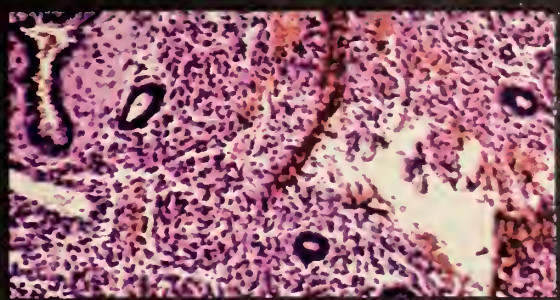
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



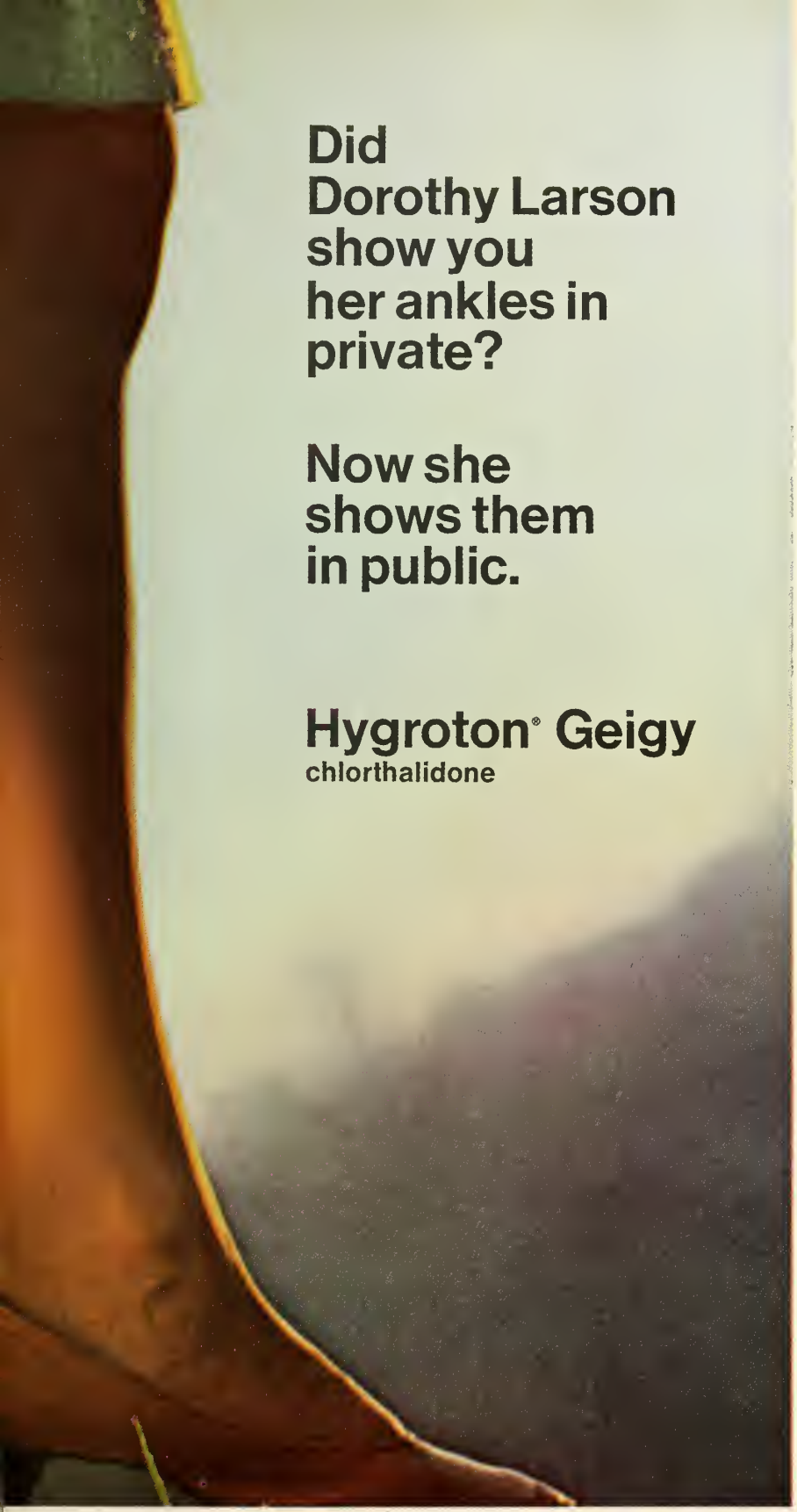
Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. ē mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Be
cause of the possibility of prog
sion of renal damage, periodic
determination of the BUN is in
cated. Discontinue if the BUN r
or liver dysfunction is aggraval
Hepatic coma may be precipita
Electrolyte imbalance, sodium
or potassium depletion may oc
If potassium depletion should
cur during therapy, Hygroton s
be discontinued and potassium
supplements given, provided



Did Dorothy Larson show you her ankles in private?

Now she shows them in public.

Hygroton® Geigy
chlorthalidone

Your office examination confirmed Mrs. Larson's ankle edema.

You prescribed Hygroton to get rid of the edema.

And you found that Hygroton is not only usually effective; it frequently costs less than other equivalent therapy.

A nice way to treat the Mrs. Larsons in your practice.

Hygroton therapy may mean troublesome side effects for some patients. And you can't prescribe it for patients with hypersensitivity to the drug or severe renal or hepatic diseases. Before writing it for your patients, please check the prescribing information. It's summarized below.

es not have marked oli-

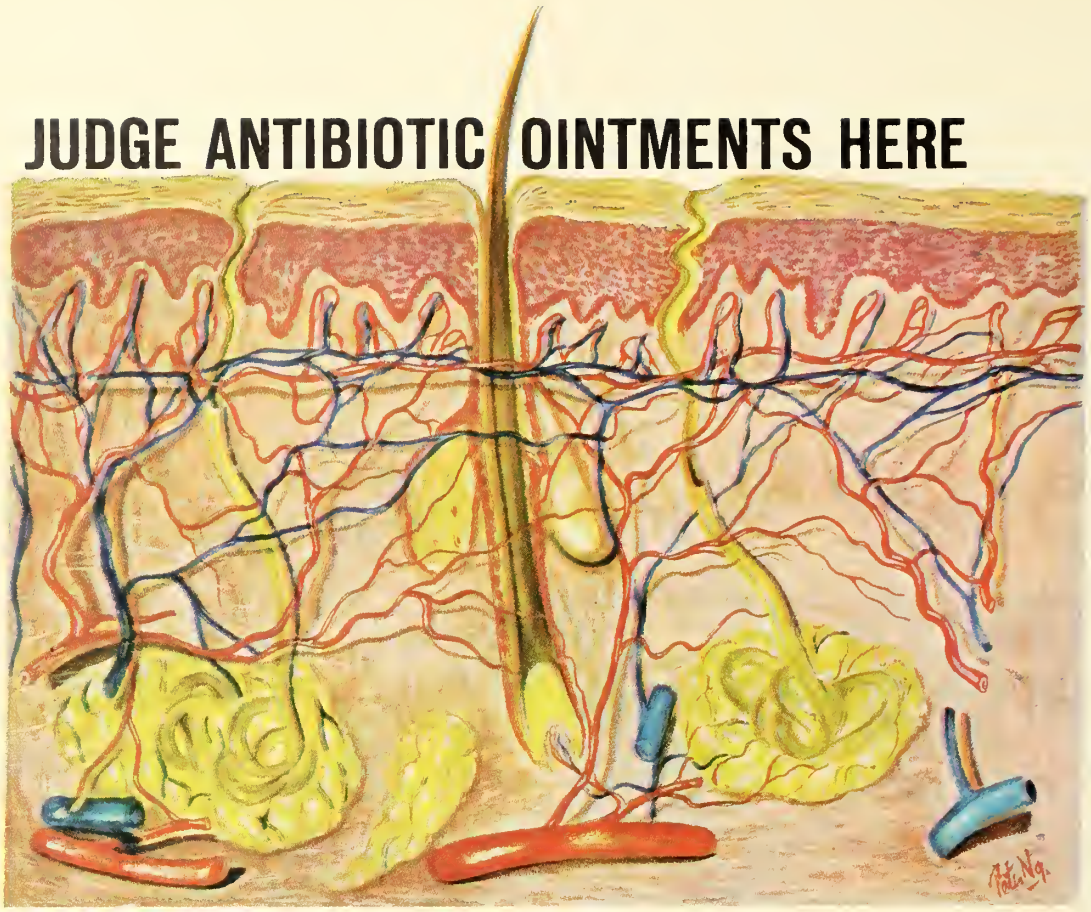
ial care in cirrhosis or
hemic heart disease and
; receiving corticoste-
H, or digitalis. Salt re-
; not recommended.
eactions: Nausea, gastric
/omiting, anorexia, con-
nd cramping, dizziness,
restlessness, hyperglyc-
eruricemia, headache,
mps, orthostatic hypo-

tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)R46-230-D
For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

H-4508

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Medicine in Fairfield County, Ohio, 1800-1850

By CHESTER P. SWETT, M. D., Lancaster, Ohio

PART I

AS ANY ORGANIZATION progresses further in time from its origins, a sensible regard for history draws the interest of some of its members. In the instance of the Fairfield County Medical Society the date is rather recent. It was organized on June 16, 1903, in the Chambers of the City Council in Lancaster Ohio. Perhaps a brief history of this Society may be undertaken at some future time.

The history of medicine in Fairfield County concerns itself with medical origins more than one hundred years prior to the above date. The City of Lancaster was founded in 1800, being laid out in lots by Ebenezer Zane. The next year witnessed an influx of settlers. The population in and around the city soon grew to respectable size. Where there is a demand there will soon be a supply.

Among the first of the medical profession to practice in Lancaster was Dr. Amasa Delano. He is believed to have arrived in late 1800. Whence he came no record exists. He was listed as a purchaser of one of the original lots, which were sold in 1801 and 1802. He was a brother-in-law of Robert Russell, a merchant of Franklintown. He apparently did not remain long and may have moved elsewhere by 1801 or 1802. Another who some sources claim to have arrived first was Dr. John Shawk. This name may be confused with that of Dr. John M. Shaug, since the pronunciation is similar. It is my opinion that John Shawk and John M. Shaug were one and the same person. Dr. Shaug was certainly one of the first, since he came to Lancaster from Kentucky over Zane's Trace in 1801. He did not move his family here until 1806.

Other Early Doctors

Dr. William Kerr came in 1801 and began his practice. He died in 1805. Dr. Ezra Torrence came from Vermont in 1804. Later he acquired a tavern and was still in practice in 1815. His death occurred in 1818. Dr. Robert Wilcox was an older man when he came in 1806 to open an office. He had served as an army surgeon in the Revolutionary War. His death occurred in 1812. Dr. Daniel Smith arrived in 1810 from Virginia. This state at that time extended to the Ohio River so Dr. Smith may not have traveled much more than 100 miles. He was a member of the Ohio legislature in 1817-1818. Sometime after that date he returned to Virginia.

Dr. James Wilson came in 1804. He was born in Loudon County, Virginia, in 1780. He practiced medicine in Lancaster until his death in 1823. He married a daughter of Thomas Sturgeon, who was an early innkeeper. Later he purchased property just north of the city park on Broad Street and adjacent to the present site of the Episcopal Church. During the War of 1812 he served as an army surgeon. Later he was elected president of the town council. One of the most signal honors paid him was accorded when he was elected as the first Master of the Lancaster Lodge No. 57 F. & A. M., which was organized in 1820.

Dr. William Irwin or Erwin was an early resident but the precise year of his arrival is not known. One source states that he began his practice in Lancaster in 1801 or 1802. Other early arrivals among the medical profession were Drs. Robert McNeill, and James White. There will be more comment concerning some of these in later paragraphs.

Early Settlements

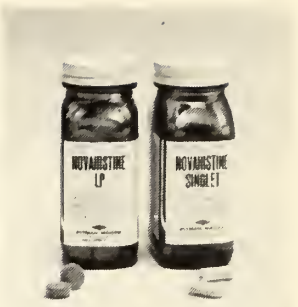
One explanation of the factors which determined the area of a county was that a citizen residing in any part of a county could travel to the county seat and return in one day either by horse and buggy or with a team and wagon. However, such a trip was not often made from the farther points. In winter and spring, due to poor condition of the roads, a source of supply nearer home was almost essential. This was the reason for villages to spring up in various stragetic points such as at crossroads or at mills. These settlements were mainly trading posts.

*A practitioner of long standing in the Lancaster area, Dr. Swett is a former member of The Council of the Ohio State Medical Association. He is a graduate of Jefferson Medical College. In addition to his numerous professional and fraternal associations, he is a member of the Ohio Historical Association.

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Besides a mill, a blacksmith shop, a grocery, and a hardware store were some of the essential places of business. Doctors in the early years found these small communities to be a very satisfactory place to begin practice.

In Fairfield County some villages were settled within two or three years after the founding of Lancaster. One such was Royalton which was settled before 1810. Dr. Silas Allen came to Fairfield County in 1800 with four sons. He settled at what later became Royalton. He died in 1825. Dr. Ezra Clarke came from Middletown, Vermont, in 1820 and also settled in Royalton. He had previously practiced in Vermont for 30 years. Also in 1820, Dr. E. L. Minor first practiced in Royalton. A little later, Dr. Minor married a daughter of Dr. Clarke. The latter moved to Lancaster in 1823, where he succeeded Dr. James Wilson who died in that year. Dr. Clarke died in 1830 and is buried in Forest Rose Cemetery. Dr. Minor may have found it a bit crowded in Royalton in the professional sense as he soon moved to Lithopolis, then called Centerville. There he continued his practice for 45 years.

Village of Royalton

This small village of Royalton must have offered opportunities for a young doctor. Still more came. Dr. M. Z. Kreider opened an office there in 1825 and remained until 1832. Dr. Rogers of Vermont also settled there in 1830. The description of the community must have impressed his friends in his home state. Before long, Dr. Paul came from Vermont and practiced there the rest of his life. Moreover, Dr. Frisbie of Vermont came and practiced for several years in Royalton. He later moved to Hancock County to live with his daughter until he died. It is amazing that so many doctors could practice in such a small community and make a living.

In Baltimore, Dr. S. S. Geohegan was perhaps the first doctor to open an office, which he did in 1825. In 1827, Dr. Luke Helmick began to practice. There will be a more detailed account of this determined young practitioner later. Dr. William Quinn hung out his shingle in 1829. A few years later, Dr. Sprague opened an office. There was a Dr. Horr or Hore who was said to have practiced here a short time. He married a daughter of Dr. Sprague and soon moved to Pickerington about 1835 or 1837.

This leads us to Violet Township and the village of Pickerington. Besides Dr. Horr there was Dr. Hood who practiced there probably in 1825 or later. In the village of Jefferson, Dr. William Talbot or Talbert was an early practitioner prior to 1824 and continued for about 30 years. Dr. Brock was an early physician in New Salem.

Dr. Simon Hyde

In Rushville, Dr. Simon Hyde was one of the first, if not the first, physician there. Here was a man of great intellect who chose to live in a small pioneer village. He was a fine Latin, Greek, and Hebrew scholar as well as a mathematician. He read his Bible in both a Latin and Greek text.

Some incidents concerning his education are interesting. He was born and reared on a farm near Norwich, Connecticut. His health during childhood was poor, and his parents considered it unwise to waste good money in sending him to college, as he might not live to graduate. Two of his brothers received college educations. As they laid aside their books, Simon began to study them. Alone and unaided he mastered the college course.

His health improved as he reached manhood. At the age of 23, he left home and made his way on foot to Ohio. This was about the year 1815. His first stopping place was Franklinton. During this stay of some two years he was often afflicted with chills and fever. His decision to seek better health was a happy and salubrious one. He took up residence in the hills of Fairfield County at Rushville. There he taught school and completed his medical studies. His practice became extensive as he became a very popular and successful practitioner. At the age of 40, he married a daughter of William Coulson, a local merchant. This union was blessed with 11 children, four of whom died in infancy. One son, William, studied medicine and practiced in Detroit.

Underground Railroad

For a number of years before the Civil War, the Underground Railroad was active in Ohio. Negro slaves were assisted in a clandestine and surreptitious manner to pass through Ohio to Canada. There were many so called stations along the route. The Negroes were concealed during the day and traveled at night. During the trip some of them became afflicted with various ailments. Rushville was a station along the route. Dr. Hyde was called upon to treat the Negroes who were ill during their brief sojourn in the village. It is quite possible that he assisted in other ways in this movement.

Dr. Hyde's vigor increased as he lived a longer time in Rushville. From a sickly child, who was expected to die at an early age, he survived through the rigors of a pioneer life and lived to age 79.

Dr. George Miesse, Sr., practiced in Dumontsville from about 1833 to 1840. He then moved to Greenville where he practiced until his death in 1876 at the age of 70.

The names of Drs. Robert McNeill and James White were mentioned earlier. Dr. McNeill came to Lancaster prior to 1820 as a young man and

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started to practice. He proved himself to be an able physician, a popular citizen, and a prominent Freemason. He married Elizabeth, daughter of Henry Arnold, who was a prominent local merchant. His practice was probably the largest of any doctor in Lancaster in the early 1830's. At the height of his career he suffered a tragic death by an accident on December 1, 1835, at the age of 44. So esteemed was he by the local Masonic fraternity, that fellow members erected a handsome monument to his memory in Elmwood cemetery. His wife survived him by nearly 60 years. As will be noted in a subsequent paragraph, he was present when the Thirteenth District Medical Society was organized. He served as vice-president in 1824 and 1825, and as president in 1826 and 1827, as well as on various committees. Little is known of his family. He had one child, John Bowman McNeill. There may have been others.

John B. was educated in the Lancaster schools and then studied law. After being admitted to the bar he became a partner of Charles D. Martin. This law firm of Martin & McNeill occupied a prominent position in the community. John became a very popular man as a leader, a citizen, and a Republican politician. He lived until about the age of 60. His eldest daughter married a Lancaster attorney, Mr. A. I. Vorys.

The other physician, Dr. James White was born in Montgomery County, Pennsylvania, June 10, 1799. His father was a Baptist preacher in Philadelphia for 25 years and later the pastor of the First Baptist Church in Lancaster, Ohio. Young James probably received his early education in Philadelphia. It is certain that he studied medicine at the University of Pennsylvania Medical School and received the degree of M. D. in 1821. He was a diligent student and graduated with honor.

In the same year he headed west and became a resident of Lancaster, where he began to practice and was successful from the start. This encouraged him to seek a partner for life. This he did in the person of Maria Elizabeth Beecher, an educated and amiable young lady, a niece of General Philemon Beecher. So far as records are available, Dr. White held the distinction of being the first doctor in Fairfield County who had received formal training in medicine and who had graduated from probably one of the best medical schools in the United States at that time. He served as the secretary of the Thirteenth District Medical Society from 1824-27 and as president in 1832. It was through the alertness of his grandson many years later that the records of this Society were saved from destruction. He was possessed of a highly commendable character, and achieved honor and distinction in his profession. He died September 26, 1868, and was buried in Elmwood cemetery. No record of his family has been found. However, it is certain that he had a son, since his grandson, Mr. E. B. White, a pharmacist, salvaged the book which contained the minutes of the Thirteenth District Medical Society.

Some of Dr. White's relatives followed him here from Pennsylvania. Besides his father, three sisters came with their father. One became the second wife of John Creed. Another sister married James Smith, a merchant. After his death, she married Joseph Grubb. A third sister married Tunis Cox, a Lancaster merchant.

We are fortunate in possessing even this much information concerning the pioneer doctors of the county. Records were poorly kept or were not even kept at all. It is impossible to determine in many instances the exact year that some of these doctors arrived. Moreover, we know less about their families. There is no record in some instances of the maiden name of their wives. Often, there is no knowledge or mention of their children. The only evidence of progeny may be that one or more of their children or descendants attained distinction in their own right.

(Continued in Next Issue)

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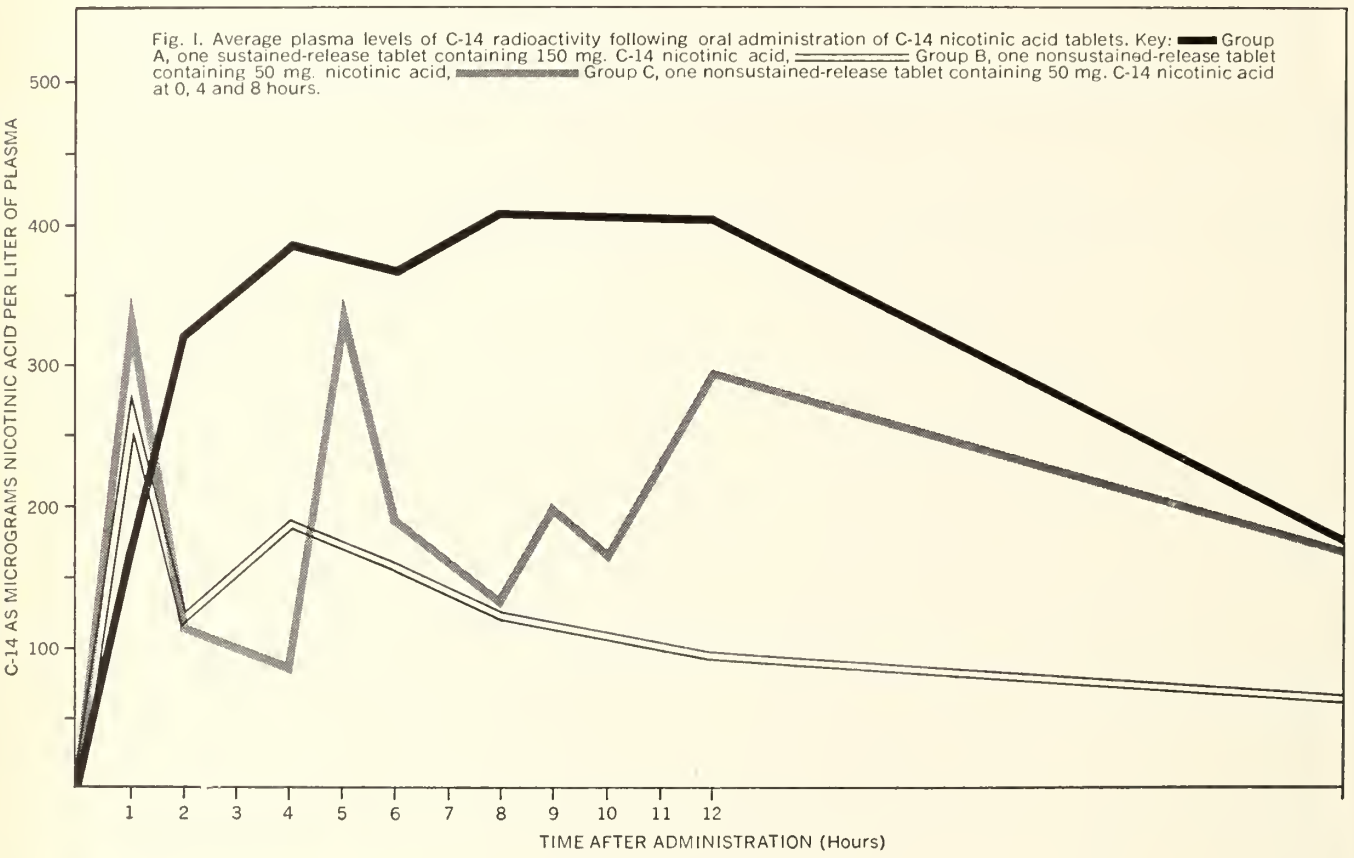
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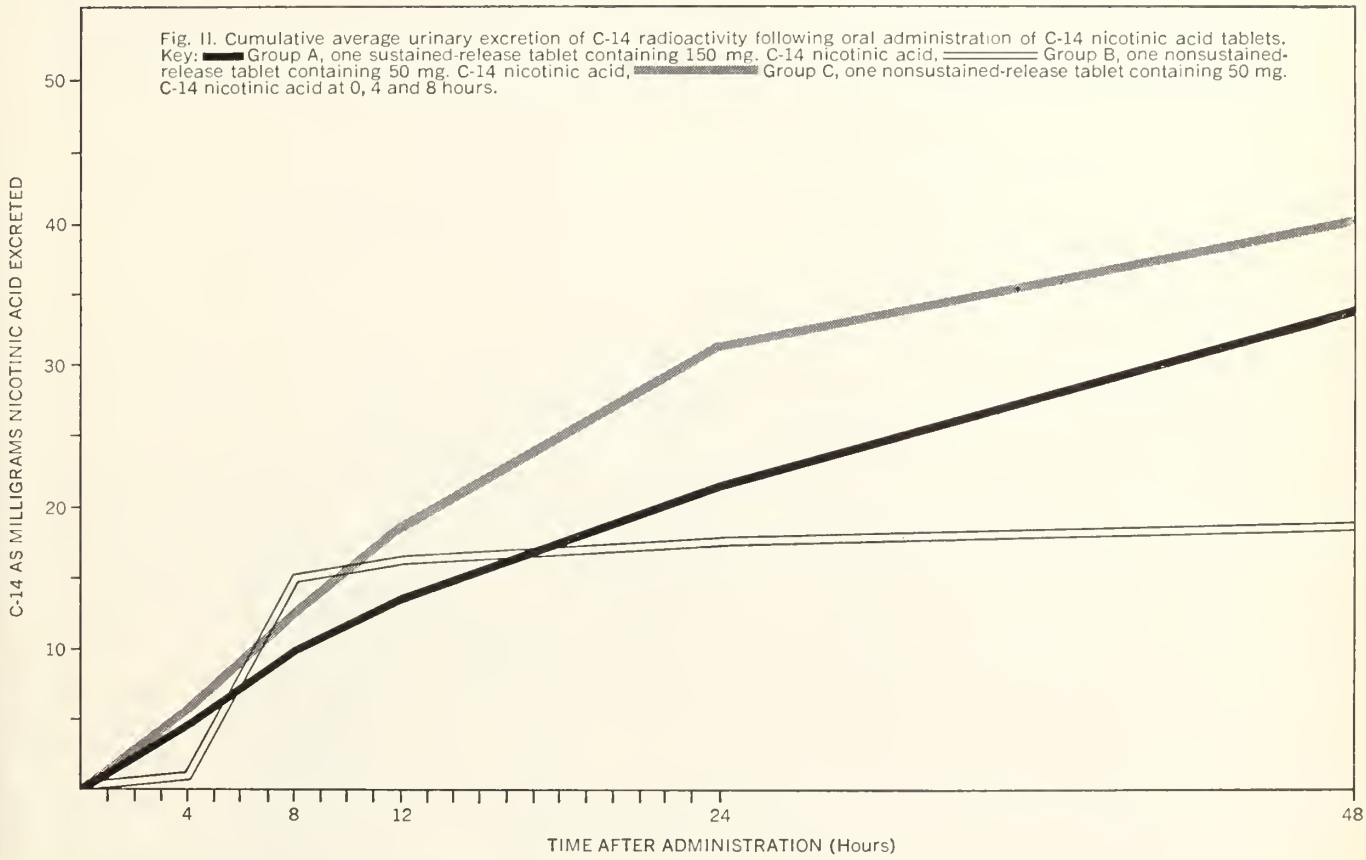
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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VOL. 64 MAY, 1968 NO. 5

Abstracts from Regional Meeting of American College of Physicians

EDITOR'S NOTE: Again this year *The Journal* is pleased and proud to publish abstracts of the papers read at the Combined Regional Meeting of the American College of Physicians for Ohio, West Virginia, and Western Pennsylvania February 23-24, 1968, in Cincinnati, Ohio. The abstracts present in concise form a wealth of information reflecting the nature of current medical research in this part of the country. We are indebted to Dr. Morton Hamburger and his Program Committee for the selection of the papers and to them and Drs. Edmund B. Flink, Richard W. Vilter, and William M. Cooper, Governors of the College for West Virginia, Ohio, and Western Pennsylvania, respectively, for permission to publish the abstracts.

* * *

A New Cerebral Vascular Syndrome Due to Internal Carotid Occlusion with Retrograde Flow in Middle and Anterior Cerebral Arteries

George Perrine, M. D., and Norman Allen, M. D., F. A. C. P., Columbus, Ohio

A previously unrecognized syndrome has been encountered in three patients in whom internal carotid artery occlusion was accompanied by unusually well developed meningeal anastomoses from posterior cerebral distribution, with prominent retrograde flow in the peripheral branches of anterior and middle cerebral arteries. The usual findings of infarction in distribution of internal carotid or middle cerebral arteries were absent. Instead, neurological deficits could be attributed to those areas supplied by proximal parts of these arteries and their perforating branches.

There was remarkable sparing of function related to cerebral convexities. Visual functions were intact, as were those of language, perception, symbolic representations, topographical orientation, spatial relationships, and memory.

Profound deficits were observed, however, in relation to functions of frontal lobe, medial cortex, and anterior basal ganglia. Grasp and sucking reflexes were present, as well as magnetic type apraxia. Pseudobulbar paralysis was intense, particularly in respect to dysarthria. Unusually severe dystonia was found, with hemiplegic or flexion distribution, and summating with partial hemiplegia to immobilize the patient. A circumscribed impairment of mental function was noted with characteristics referable to frontal lobe disease.

Angiography disclosed bilateral internal carotid occlusion in two patients and unilateral carotid occlusion with main trunk cerebral artery stenosis in the third. It was concluded that the angiographically demonstrable reversal of flow from posterior cerebral to distal middle and anterior cerebral arteries served to spare the cortical convexities and to render vulnerable these areas supplied by the proximal parts of these arteries.

* * *

The Control of Hemorrhage with a Combination Of Norethynodrel-Mestranol

Helen I. Glueck, M. D., F. A. C. P., and Herbert Flessa, M. D. (Associate), Cincinnati, Ohio

Previous studies of the effects of estrogens on ground substance and capillary permeability led to the present investigations. Tablets each containing

norethynodrel 5 mg and mestranol 0.75 mg were used to treat Von Willebrand's disease (V. W. B. long bleeding time quantitative defect of VIII) hereditary hemorrhagic telangiectasia (H. H. T.), hemophilia, an obligatory hemophiliac carrier, and congenital thrombopathia.

In five patients with V. W. D., the bleeding time was prolonged (10 min. or >), and factor VIII was 12 to 56 per cent of normal. In four of five, following therapy the bleeding time shortened, and VIII levels rose to 80 to 160 per cent. Patient 1 had 27 previous hospitalizations for nasal, GI, GU, and cerebral hemorrhage; no hospitalizations since therapy. Patient 2 had continuous epistaxis, three surgical procedures for GI bleeding, and missed 120 work days in two years. Epistaxis is absent and she works uninterruptedly. Two mildly affected patients previously bled with extraction. Following five weeks therapy, dental surgery was uneventful. Patient 5, the only male, showed neither clinical nor laboratory improvement.

Five females with H. H. T. were treated from 2½ years to nine months. Patient 1 had an initial Hb. of 5, continuous epistaxis and two surgical procedures for GI bleeding. Hemorrhage is controlled and Hb. stable at 12. Patients 2 and 3 had epistaxis in spite of nasal skin grafts. Epistaxis is reduced, with normal hemoglobin maintained in both. An earlier trial with estrogens (Patient 3) was unsuccessful. Small doses controlled epistaxis in Patient 4. Patient 5 has control of epistaxis, but hemoptysis from an A. V. fistula persists.

Two hemophiliacs showed no clinical or laboratory improvement. An obligatory carrier of VIII defect bled previously with dentistry. After 4 weeks therapy, VIII levels rose from 12 to 32 per cent of normal, and extraction was uneventful. Therapy was ineffective in one subject with congenital thrombopathia.

Dosage varied from 1 to 3 tablets daily. With large doses, edema, migraine, metrorrhagia, gynecomastia, chloasma gravidarum, and choked disks were observed. One patient developed breast cancer.

Patients with V. W. B. and H. H. T. appear to benefit from norethynodrel-mestranol combinations. The mechanism of this effect is under study.

* * *

In Vivo Hemolysis of Rat "PNH" Cells

Neil Baum, M. D., Charles E. Mengel, M. D., F. A. C. P., and Stanley P. Balcerzak, M. D., F. A. C. P., Ohio State University, Columbus

In previous studies we showed that normal human RBSs (red blood cells) incubated with reduced glutathione (GSH) developed all of the in vitro lytic features characteristic of PNH (paroxysmal nocturnal hemoglobinuria). In the present studies RBCs from rats were incubated in solutions of GSH (0.33 M) for 15 to 45 minutes at 37° C, or saline solutions of comparable pH and ionic strength.

GHS-treated rat RBCs showed lysis (30 to 50 per cent) in rat serum that was completely inhibited by prior heating of the serum at 56° C for 30 minutes. No lysis in serum occurred with control-incubated cells. Testing of pH at 0.2 intervals revealed a single sharp peaked optimum for lysis at pH 8.4 (e.g., 0 per cent lysis at pH 6.2 and 9.6). At the optimum pH, lysis was increased by the addition of thrombin e. g. 30 per cent lysis increased to 56 per cent). Rat RBCs also showed a 50 per cent decrease of acetylcholinesterase activity compared to control-incubated cells. In contrast to normal rat RBCs and control-incubated RBCs, the GSH-treated RBCs had a significant shortening of survival (t ½ of 57 hours). Intravenous injection of 1 ml. of GSH-treated RBCs produced marked hemoglobinemia and hemoglobinuria.

These data demonstrate that normal rat RBCs, made to develop in vitro PNH-like lytic features also have a shortened survival in vivo. They show that the potential development of corpuscular defect(s) necessary for PNH lysis is not unique to the human erythrocyte. The GSH-treated normal RBC provides the opportunity to define the relationship between in vitro and in vivo features of complement activity and to evaluate its relationship to in vivo PNH lysis.

* * *

Myelofibrosis and Hemolytic Anemia

Thomas Hathhorn, M. D., and John J. Will, M. D., F. A. C. P., Cincinnati, Ohio

An unusual case of myelofibrosis associated with hemolytic anemia, hemoglobinemia, and hemoglobinuria will be presented. A 29 year old white woman experienced the abrupt onset of persistent intravascular hemolysis associated with intermittent spherocytosis, progressive bone marrow failure, myelofibrosis, and extramedullary hematopoiesis.

Serum hemoglobins varied from 12 to 90 mg. per cent urinary hemoglobin from zero to 803 mg. daily, and urinary iron from 3 to 16 mg. daily. Hemosiderinuria was abundant and continuous. Serum haptoglobin was absent and hypogammaglobulinemia was present. Fecal urobilinogen was 992 E. U.

Although a blood transfusion requirement equivalent to 1 to 1½ units weekly existed, tests for warm and cold agglutinins and hemolysins, acid hemolysins, thrombin lysis, Donath-Landsteiner test, and Coombs test were repeatedly negative. Autohemolysis was normal and sucrose lysis resulted in only 9.1 per cent hemolysis. Erythrocyte osmotic fragility resulted in 5.5 per cent hemolysis in 9.55 per cent saline and increased to 33.9 per cent hemolysis after 24 hours erythrocyte incubation: Erythrocyte acetylcholinesterase was 459 m./hr./ml. RBC.

Ferrokinetic studies were indicative of bone marrow failure with only 14 per cent ^{59}Fe erythrocyte incorporation at 14 days, while ^{51}Cr studies demonstrated a severe hemolytic anemia with an erythrocyte half life of ten days without splenic sequestration.

Bone marrow failure and hemolytic anemia improved with prednisone and fluoxymesterone treatment. The erythrocyte count became normal although reticulocytosis and hemosiderinuria persisted.

Overt hemolytic anemia is unusual in myelofibrosis. Donor and patient erythrocytes were involved but immune mechanisms were not demonstrated. Deranged erythropoiesis and erythrostasis causing imperfect, fragile erythrocytes leading to hemolysis will be considered.

* * *

Cephaloridine and Cephalothin Pharmacodynamics in Uremia

Robert L. Perkins, M. D., F. A. C. P., E. Smith, M. D., Samuel Saslaw, M. D., F. A. C. P.

From the Department of Medicine, The Ohio State University College of Medicine, Columbus, Ohio

The high antibacterial activity and low toxicity of cephalothin and cephaloridine suggest their use in infected uremic patients. However, preliminary reports indicate that high and prolonged, potentially toxic serum levels of either cephalosporin may occur with reduced renal function, and that peritoneal dialysis may significantly reduce these concentrations. For these reasons, the comparative pharmacodynamics of cephalothin and cephaloridine were evaluated in a cross-over study in five chronically uremic patients before and during peritoneal dialysis. After single 1 gm. intramuscular injections, decay rates were determined for antibiotic concentrations and antibacterial activity (ABA) in serial serum, urine, and dialysate samples. Cup-plate antibiotic assays were obtained using *Sarcina lutea;* ABA was determined against a penicillin-resistant staphylococcus, group A streptococcus, enterococcus, Klebsiella, and an Escherichia.

Peak serum cephalothin concentrations (mean 41 mcg./ml.) occurred at 1 to 2 hours after injection; relatively high levels (11 to 19 mcg./ml.) persisted for 24 hours; and significant amounts (5 to 8 mcg./ml.) remained at 48 to 72 hr. Peritoneal dialysis in the same patients resulted in approximately 18 per cent and 50 per cent reduction, respectively, in peak and 24 hour sreum levels. Baseline cephaloridine serum concentrations (mean peak 45 mcg./ml.; 8 to 38 mcg./ml. at 24 hr.) were comparable to cephalothin, but decay curves were less effected by dialysis. Peak dialysate concentrations of cephaloridine and cephalothin occurred at 1 to 6 hr. after injection and subsequent levels remained at 25 to 50 per cent of serum values; proportionately, lower concentrations of cephaloridine than cephalothin were observed in dialysate from four of five patients.

After cephalothin, high serum bactericidal effect against the group A streptococcus persisted $>$ 48 hr., but for the staphylococcus was absent after 12 hours; negligible bactericidal effect was present for the E. coli, Klebsiella, and enterococcus. Cephaloridine produced serum ABA of greater magnitude and duration against the staphylococcus and streptococcus, and significant effect against the E. coli and Klebsiella. Peritoneal dialysis after either antibiotic caused only minimal reduction of serum ABA despite quantitative reduction of antibiotic levels.

* * *

Candida Endocarditis Surrounding a Starr-Edward's Prosthetic Valve

Chatrchai Watanakunakorn M D., Judith Carleton, B. A., Morton Hamburger, M. D., F. A. C. P., and Leonard M. Goldberg, M. D.

From the Infectious Disease Division, Department of Medicine, The University of Cincinnati College of Medicine

A case of endocarditis caused by Candida parasillosis surrounding the base of a Starr-Edward's prosthetic valve in a 40 year old man is reported. This man had previously suffered from two bouts of pneumococcal endocarditis caused by two different serotypes of pneumonococcus. Because of his marked degree of aortic insufficiency due to perforation of one of the aortic cusps, he underwent open heart surgery under cardiopulmonary bypass for nearly three hours and a Starr-Edward's prosthesis was used to replace the aortic valve. Three and one half months later he developed fever and subconjunctival hemorrhage. Seven of ten blood cultures grew Candida parasillosis. He was treated with amphotericin B but his aortic prosthesis became progressively incompetent. He was operated on again under cardiopulmonary bypass. At operation, bead-like friable small vegetations were found surrounding the base of the Starr-Edward's prosthesis, instead of the large mass of vegetation commonly encountered in Candida endocarditis.

After 32 days of treatment with amphotericin B, blood cultures in conventional medium became negative. However, blood cultures in special hypertonic broth yielded Candida parasillosis, although L-forms were not actually seen.

* * *

Histoplasma Pericarditis

Samuel Saslaw, M. D., F. A. C. P., Robert G. Norfleet, M. D., and David J. Dapra, M. D.

From the Department of Medicine, The Ohio State University College of Medicine, Columbus, Ohio

To date, only 14 cases of acute pericarditis presumably due to *Histoplasma capsulatum* have been reported. The specific organism was cultured from pericardial fluid in only two patients. Histopathologic examination of biopsy material has been the sole basis for the diagnosis in two cases and serologic

data supported the diagnosis in the remaining ten. Two patients with nonfatal acute pericarditis have been studied here, a 39 year old male and a 19 year old female. The diagnosis of histoplasmosis was based on conversion of the histoplasmin skin test and rising titer in the former and by an exceptionally high yeast phase complement fixation (1:320) and 1:40 collodion agglutination titer in the latter patient. In the second patient, blood obtained for serologic study was taken prior to skin test. In the first patient, the rise in titer was observed after a single skin test and the possible effect of the skin test on serologic results was considered. Thus, using the same skin test antigen and serologic tests, a total of 187 persons were studied over a 12-week period; 90 (48.1 per cent) were skin-test positive. No significant antibody rise was observed in the yeast phase complement fixation or histoplasmin collodion agglutination tests routinely employed in this laboratory. When histoplasmin was used as antigen in complement fixation tests, 24 of 90 (26.7 per cent) skin-test positive and none of the skin-test negative persons developed significant antibody titer increases. None of the 187 persons showed significant titer increases with the commercially-available histoplasmin latex agglutination tests. These differences could account for discrepancies in studies from various laboratories. Thus, it could be concluded from these studies that the first patient's infection was also due to histoplasma. Histoplasmosis should be considered in the etiology of pericarditis, particularly in endemic areas. A single skin test when properly employed is a valuable tool and constant monitoring of its effect on serologic tests employed in each laboratory is necessary in order properly to interpret serologic data.

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Bronchial Carcinoid Causing the Ectopic ACTH Syndrome

John E. Jones, M. D., F. A. C. P., Stanley R. Shane, M. D. (Associate), Enid Gilbert, M. D. (by invitation), and Edmund B. Flink, M. D., F. A. C. P.

From the Departments of Medicine and Pathology, West Virginia University Medical Center, Morgantown, West Virginia

The occurrence of Cushing's syndrome with nonendocrine neoplasms has been called the Ectopic ACTH syndrome. A 67 year old woman with a two-month history of increasing fatigue, acne, easy bruising, epistaxis, changing facial and body contour, and dyspnea was admitted for evaluation. The examination revealed a seriously ill woman with typical findings of Cushing's syndrome. The serum potassium was 2.3 mEq/liter, the CO_2 content 38 mEq/liter. Chest x-ray showed a left pulmonary lesion. Steroid studies appear in the table below. She was treated initially with metyrapone 250 mg. each six hours and later dexamethasone 1 mg. nightly was added. In spite of a stormy and complicated clinical course, during the next five weeks there was gradual improvement and she underwent thoracotomy and resection of a bronchial carcinoid.

	Pre Op	Post Op
Plasma Corticoids (ug%) 8am/12mn	120/115	18/10
Urine 170H/17KS (mg/24hrs)	44/32	8.3/6
Response to Metyrapone (Mg Rise Over Baseline)	0.8 mg	16.2
Urine 170H/17KS (mg/24hrs) during Metyrapone therapy	37/25	....
Urine 170H/17KS (mg/24hrs) during combined Metyrapone and Dexamethasone therapy	11/6.6	....

The signs of Cushing's syndrome had significantly resolved prior to surgery and completely resolved thereafter while receiving no drug therapy. ACTH bioassay of the carcinoid tumor (done by Drs. Liddle and Orth, Vanderbilt University) revealed 95 mU/mg wet tissue weight.

The Ectopic ACTH syndrome has been recognized with a variety of nonendocrine tumors. Prominent features of most of these cases include hypokalemic alkalosis, elevated urinary and plasma corticoids, and failure of dexamethasone suppression.

* * *

Interactions of Obesity, Insulin and Glucose Levels in Hypertriglyceridemia

Starr Ford, Jr., M.D., Richard C. Bozian, M.D., F.A.C.P., and Harvey C. Knowles, Jr., M.D., F.A.C.P.

From the Department of Medicine, The University of Cincinnati College of Medicine, Cincinnati, Ohio

Hypertriglyceridemia is frequently associated with obesity, abnormal glucose tolerance, and hypersecretion of insulin. In this study, further quantitative observations of these variables were made to clarify their interactions.

Average fasting plasma triglyceride levels were determined in 20 individuals consuming ad libitum diets. Three hour glucose tolerance tests were performed with measurement of plasma immunoreactive insulin levels.

Triglyceride levels correlated with relative body weight (r-0.68, $p<0.01$) and glucose (r-0.64, $p<0.01$) and insulin levels (r-0.68, $p<0.01$) during the tolerance tests. The results of multivariate analysis indicate that body weight and insulin levels were highly interrelated variables and acted as a single factor, correlation with fasting triglyceride levels was highly significant (r-0.72, $p<0.001$). In addition blood glucose levels were related to triglyceride levels ($p<0.02$) independent of insulin levels and obesity. Paired glucose tolerance tests in three patients before and after induction of hypertriglyceridemia by high carbohydrate feeding were essentially identical.

These findings support the view that fasting triglyceride levels in hypertriglyceridemic patients are

largely determined by circulating levels of glucose and insulin and that insulin levels are highly dependent upon the degree of obesity present.

* * *

Hypertonic Sodium Chloride Infusion as a Test for Hyperparathyroidism

Stanley R. Shane, M. D. (Associate), Edmund B. Flink, M. D., F. A. C. P., and John E. Jones, M. D., F. A. C. P.

From the Department of Medicine, West Virginia University Medical Center, Morgantown, West Virginia

Hypertonic sodium chloride infused into a control and hyperparathyroid group of patients has been reported to increase calcium excretion significantly only in the patients with hyperparathyroidism. In order to evaluate further the diagnostic utility of the hypertonic saline infusion test, 25 infusions were performed in 19 subjects, four with hyperparathyroidism and 12 who served as control subjects (six with nephrolithiasis and hypercalciuria and six with nephrolithiasis without hypercalciuria). On the third or fourth day of a low calcium (250 mg.) low phosphorous (700 mg.) diet, each received an infusion of 0.125 ml. of 5 per cent NaCl per kg. body weight per minute for 45 minutes. Twenty-four hour urine collections the day before and day of infusion were analyzed for calcium, phosphorous, magnesium, and creatinine. The results expressed as the mean 24-hour urine calcium excretions were as follows:

Hyperparathyroidism, Baseline — 468 mg., NaCl infusion — 555 mg. (Mean increase = 87 mg.).

Nephrolithiasis with hypercalciuria, Baseline — 258 mg., NaCl infusion — 348 mg. (Mean increase = 90 mg.).

Nephrolithiasis without hypercalciuria, Baseline — 134 mg., NaCl infusion — 183 mg. (Mean increase = 49 mg.).

One patient with nephrolithiasis and hypercalciuria had a positive hypertonic saline infusion test by previously established criteria. Surgical exploration revealed normal parathyroids. Another patient with proven hyperparathyroidism had a negative hypertonic saline test. The data suggest that the infusion test does not differentiate patients with hyperparathyroidism from those with nephrolithiasis and hypercalciuria and, therefore, is probably not suitable as a diagnostic test for hyperparathyroidism.

* * *

Reexamination of the Hemodynamics Of Hypertension

Edward D. Frohlich, M. D. (Associate), Robert C. Tarazi, M. D., and Harriet P. Dustan, M. D., F. A. C. P.

From the Research Division, Cleveland Clinic, Cleveland, Ohio

Increased vascular resistance is considered the hemodynamic hallmark of hypertension since cardiac output is said to be normal. This assumption was reinvestigated in 96 untreated hypertensive patients who were compared with 25 normotensive volunteers. In all patients, detailed studies including renal arteriography permitted classification. A summary is shown in the accompanying Table 1.

Thus, hemodynamic findings differ significantly with respect to type of hypertension. Cardiac output, while normal only in pheochromocytoma and renal parenchymal disease, was increased in renal arterial disease ($p<.005$) and labile hypertension ($p<.001$), and low-normal in essential hypertension. When essential hypertensives are subdivided, output was reduced ($p<.05$) in those with nonfailing cardiac enlargement; but all, whether having normal or enlarged hearts, had lower output than patients with renal arterial disease ($p<.001$). Heart rate and peripheral resistance were elevated in all except labile hypertension ($p<.001$). Therefore, hypertension no longer should be considered a homogeneous disease ascribed only to increased vascular resistance; hemodynamics vary significantly depending upon type and stage of disease.

* * *

Serum Renin Concentration and Aldosterone Excretion in Essential Hypertension

Paul E. Wisenbaugh, M. D., F. A. C. P., Charles Hull, M. D., and Josephine Garst, Ph. D., Cleveland, Ohio

Recently it has been stated that a significant number of patients with "essential hypertension" may in fact have normokalemic primary aldosteronism. A study to investigate this possibility has been in progress at this hospital for the past 15 months.

TABLE 1. *(Dr. Edward D. Frohlich, et al.)*

GROUP	No.	M.A.P (mm Hg)	Heart Rate (beats/min)	Stroke Index (ml/beat)	Cardiac Index (L/min/M²)	T.P.R. (mm Hg/ml/min)
Normal	25	93	68	45	3.0 (.09)*	.017
Labile Hyper.	6	108	65	57	3.9 (.15)	.015
Ess. Hyper.	55	139	78	37	2.8 (.08)	.027
Normal Heart	37	128	78	40	3.1 (.09)	.023
Enl'gd. Heart	18	146	77	36	2.7 (.12)	.030
Renovasc. Hyper.	23	130	82	44	3.6 (.16)	.021
Ren. Paren. Hyp.	8	131	79	42	3.3 (.15)	.023
Pheochron.	4	134	76	40	3.0 (.15)	.024

* ± Standard Error

All patients admitted to the hospital with a blood pressure of 150 90 mm Hg. or more are screened for study. Those whose hypertension persists beyond the first week in the hospital are subjected to careful clinical evaluation to attempt to establish a cause for their hypertension. Patients who are found to have no demonstrable cause for their hypertension other than possible normokalemic aldosteronism and whose hypertension is persistent are subjected to further study under carefully controlled conditions.

After the patient has attained electrolyte balance on a diet containing 110 mEq. of sodium and 70 to 80 mEq. of potassium per day, 24 hour urines are collected for three days and the 24 hour excretion of sodium, potassium, and aldosterone detemined. On the first and third day of this period, serum renin concentration is measured. The diet is then changed to one containing 10 mEq. of sodium and 70 to 80 mEq. of potassium, and 24 hour urinary excretion of aldosterone, sodium and potassium are measured during a seven day period. Serum renin is measured on each of the last three days of this period.

Of 32 patients investigated thus far, none has been found to have all of the criteria for primary aldosteronism.

* * *

Two Years Experience with a Large Cardiac Monitoring Unit in a Community Hospital

Richard Charles, M. D., Vijay R. Sanghvi, M. B., B. S., and E. Gordon Margolin, M. D., F. A. C. P., Jewish Hospital, Cincinnati, Ohio

The Jewish Hospital of Cincinnati established a 20-bed cardiac monitoring unit in February, 1966. Because this is a community hospital, it was decided that each staff physician whose patients had myocardial infarction, suspected myocardial infarction, cardiac arrhythmia, or potential cardiac arrhythmia could choose to admit that patient to this monitored area. This philosophy differs from that of many units wherein only selected and severe cases of myocardial infarction are chosen for monitoring. The large size of the area permits monitoring up to ten or 14 days. The patients are kept in private or semi-private rooms not under direct vision by the nursing staff. The monitors serve only as electronic watchers of cardiac rhythm and do not substitute for routine or standard nursing care. Successful operation has depended on the cooperation of all the individual physicians, each with his own method of handling such patients, on the presence of a part time physician director of the unit, and largely upon the special skills and education acquired by the nursing staff and the house staff. An offshoot of this large unit has been a remarkable increase in education of the attending staff in matters of cardiac disease, arrhythmia, and resuscitation. Each case is summarized on prepared data sheets and data sorting is available through the Computer Center of the University of Cincinnati College of Medicine.

Normal Heart Sounds in Man; An Analysis in 196 Normal Adult Subjects

Robert J. Adolph, M. D., F. A. C. P., Maria T. Tenconi, M. D., Michael J. Labance, M. S., and Noble O. Fowler, M. D., F. A. C. P.

From the Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio

Auscultatory evaluation of splitting of the first and second heart sounds aids in recognition of right bundle branch block (RBBB), left bundle branch block (LBBB), atrial septal defect (ASD), pulmonary stenosis, and pulmonary hypertension. The intervals between the Q wave and the two major components of the first (S_1) and second (S_2) heart sounds were analyzed by computer from phonocardiograms of 196 normal adults, ages 21 to 68 years.

Audible splitting of S_1 is common in RBBB, but was detectable in 83 per cent of 196 normal subjects (split 0.03 sec). Normal splitting must be distinguished from systolic ejection sounds and presystolic gallop sounds by location, respiratory effect, and palpation.

When upright, S_2 is normally single in expiration and audibly split in inspiration. When corrected for rate changes, inspiratory splitting was entirely caused by delay in P_2 and not by earlier A_2.

Audible expiratory splitting of S_2 (0.03 sec) occurred in 22 subjects (17 per cent of subjects 21 to 30 years, but only 4 per cent, ages 51 to 68 years). This normal finding must be separated from the expiratory splitting of RBBB, ASD, and pulmonary hypertension by postural effects, respiratory variation, quality of P_2, and associated murmurs.

S_2 was single in both phases of respiration in 22.5 per cent of patients 21 to 30 years, and in 61.5 per cent, ages 51 to 68 years. Hence, this sign is less valuable after 50 years of age as an indication of abnormally prolonged left ventricular ejection (LBBB, severe aortic stenosis). Expiratory splitting of S_2 more likely indicates prolonged right ventricular ejection (ASD, RBBB, pulmonary hypertension) after age 50.

* * *

A Critical Appraisal of Current Scalar Electrocardiographic Criteria for the Diagnosis of Left Ventricular Hypertrophy

Ralph C. Scott, M. D., F. A. C. P., Robert J. Norris, M. D., David L. Rowlands, M. D., Emmett Conyers M. D., and Kevin E. Bove, M. D., Cincinnati, Ohio

The accurate electrocardiographic (ECG) diagnosis of left ventricular hypertrophy is of considerable importance. Many ECG criteria have been proposed over the years. It is difficult if not impossible to remember all of these and certainly not necessary to employ them all.

This study is designed to evaluate the sensitivity and specificity of a battery of 33 proposed ECG

criteria for the diagnosis of left ventricular hypertrophy.

Three hundred cases were studied at autopsy by means of a chamber partition technique. With this method of dissection, the individual ventricular chambers can be weighed, and thus isolated or combined ventricular hypertrophy accurately assessed.

By comparing each proposed ECG criteria with the findings at autopsy a critical appraisal was made of the accuracy of these criteria.

* * *

Intestinal Atony in Progressive Systemic Sclerosis (Scleroderma)

Norton J. Greenberger, M. D. (Associate), William O. Dobbins, III, M. D., and Richard D. Ruppert, M. D. (Associate)

From the Departments of Medicine, The Ohio State University College of Medicine, Columbus, Ohio, and the Duke University Medical Center, Durham, North Carolina

Recent studies have indicated that small bowel involvement occurs frequently in systemic sclerosis. However, only a few patients have developed grossly impaired peristalsis or "intestinal atony." We have studied such a patient who had refractory stasis of intestinal contents with severe malabsorption, malnutrition, and intestinal obstruction. The patient had steatorrhea, impaired absorption of vitamin B_{12} and d-xylose, hypocalcemia, and hypoalbuminemia. Hypoproteinemia was due to excessive enteric protein loss which has not been previously described in scleroderma. Light microscopy revealed a normal jejunal mucosa, atrophy of smooth muscle, and striking deposition of collagen fibrils in the submucosa, muscularis externa, and serosa. Electron microscopy revealed normal smooth muscle organelles. A significant finding was the marked paucity of smooth muscle nexuses (cell junctions). Nexuses are important in the propagation of action potentials in smooth muscle. The loss of muscle cell to muscle cell contact may well have resulted in nonsynchronized intestinal muscular contractions and could account for the intestinal dilatation and atony found. Of 13 cases of intestinal atony in scleroderma reviewed from the literature, ten had Raynaud's phenomenon, nine had skin changes, and six had x-ray changes of esophageal involvement. All 13 had small bowel dilatation and obstructive symptoms of six months to two years duration. Ten of 13 (77 per cent) died within one year after developing atony. All three survivors had undergone extensive intestinal resections. It is possible that removal of a hypomotile segment of bowel resulted in more effective passage of intestinal contents as well as reversal of stasis-induced bacterial overgrowth.

* * *

Evaluation of a Long-Acting Intra-Articular Steroid in Rheumatoid Arthritis

Evelyn V. Hess, M. D., Nathan R. Abrams, M. D. (Associate), George P. Balz, M. D., and Joseph E. Levinson, M. D.

From the Department of Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio

The judicious use of intra-articular steriods still has a therapeutic role in the treatment of rheumatoid arthritis. Careful evaluation and long-term follow-up are required therefore, to assess new steroids. Sixty-six patients were selected for evaluation of triamcinolone hexacetonide, an adrenocorticoid reported to have a prolonged local action. All had active synovitis and only a few had had previous intra-articular steroids. The observer's objective and the patient's subjective analysis were recorded and scored.

Fifty of the 66 patients had rheumatoid arthritis and the remainder osteoarthritis. A total of 109 injections were given at a concentration of 20 mg. or 40 mg./ml. An effective response was noted within 24 hours in 74 of the 109 injections and in the majority of the remainder within 72 hours. Duration of effective response was up to 4 weeks in 20 injections, 8 weeks in 18, 12 weeks in 21, 16 weeks in 20, and over months in 23 injections. Only nine of the 66 patients had a poor response. Knee joint effusions frequently responded to only one injection. The incidence of side effects was low. Two patients complained of flushing of the face and three had some increase in joint pain for 24 hours postinjection.

The majority of patients have been followed for one year and clinical and radiological observations are in progress. To date, no untoward effects have been observed. Triamicinolone hexacetonide would appear to be a potent safe intra-articular steroid with a prolonged local action.

* * *

The Influence of Original Renal Disease On the Fate of Renal Allografts

Earl Smith, M. D., Ray W. Gifford, Jr., M. D., F. A. C. P., Satoru Nakamoto, M. D., Ralph A. Straffon, M. D., Kenneth Tung, M. D., David C. Humphrey, M. D., F. A. C. P., and Donald G. Vidt, M. D.

From the Cleveland Clinic Foundation, Cleveland, Ohio

The results of 132 renal allotransplantations performed in 109 patients at the Cleveland Clinic between January, 1963 and October, 1966, were reviewed to test the hypothesis that patients with chronic glomerulonephritis, an immunologic disease, should reject transplanted kidneys more readily than patients with other types of renal disease. The one and two year survival rates for renal allografts obtained from living donors was 78 per cent and 56 per cent respectively for patients with chronic glomerulonephritis compared to 25 per cent at both one and two

years for patients with chronic pyelonephritis. The one and two year survival rates of cadaveric allografts was 39 per cent and 26 per cent respectively for patients with chronic glomerulonephritis compared to 32 per cent and 23 per cent for patients with chronic pyelonephritis. The two year survival rate for cadaveric renal allografts implanted into patients with polycystic disease was 43 per cent (3 of 7). The two year survival rate for cadaveric renal allografts implanted into patients with various other types of renal disease was 30 per cent. Patient survival, though parallel, was somewhat better than allograft survival because some patients were maintained by hemodialysis after failure of the allograft. Among patients with pyelonephritis or glomerulonephritis, infection was the cause of death in 65 per cent of those who died. Pathologic examination of 53 allografts obtained from patients with chronic glomerulonephritis showed evidence of acute or chronic rejection in 23. Nine of 20 allografts obtained from patients with pyelonephritis showed evidence of acute or chronic rejection.

It is not apparent from this study why allografts obtained from living donors have better one and two year survival rates when implanted into patients with chronic glomerulonephritis than into patients with chronic pyelonephritis. The difference in survival of allografts is not so great when cadaveric kidneys are used. It is concluded that patients with chronic glomerulonephritis accept renal allografts as well if not better than patients with other types of renal disease.

* * *

Self-Induced Water Intoxication Aspects of Abnormal Water-Balance States

M. Naeem-Ul Haque, M. B., B. S., and Isaac Kahn, M. D.
(Introduced by E. Gordon Margolin, M. D., F. A. C. P.)

From Longview State Hospital, Cincinnati, Ohio

A 62 year old white woman with a diagnosis of involutional psychosis was admitted in stupor to the Medical Ward of Longview State Hospital.

The patient had been up and about the day prior to admission and was reported to have been drinking frequently from a water fountain. Physical examination was entirely negative except for her stuporous state, a distended urinary bladder, and bilaterally positive extensor plantar reflexes.

Spinal fluid examination was normal. Emergency blood chemistry determinations were as follows: Serum Na was 100 mEq/Liter; Serum Cl was 89.9 mEq/Liter; Bun was 5 mg./100 ml. Urinalysis was unremarkable except for a specific gravity of 1.001. Serum and urine osmolalities determined at the same time were 248 mOs/Liter and 77 mOs/Liter respectively.

An infusion of 300 cc. of 5 per cent sodium chloride was given over a period of four hours after which all further fluids were withheld. Within the following 24 hours, the patient diuresed six liters and was fully conscious, having no recollection of the events leading to her stupor. A repeat serum sodium and chloride at this time were 130 and 105 mEq/Liter respectively. Further laboratory studies tended to rule out any of the disease states known to cause water retention.

The patient concerned represents an important problem in differentiation between inappropriate A. D. H. syndrome and water intoxication, and permits a discussion of the physiology of water handling.

It is also the intention of this presentation to emphasize the fact, not generally recognized, that a physically normal person can develop water intoxication by oral ingestion of more water than the kidneys can excrete per unit time.

* * *

Selectivity Index as a Guide to Treatment in Heavy Proteinuria

William E. Miller, M. D., Sharad D. Deodhar, M. D., Ray W. Gifford, Jr., M. D., F. A. C. P., David C. Humphrey, M. D., F. A. C. P., and Donald G. Vidt, M. D.

From the Cleveland Clinic Foundation, Cleveland, Ohio

Cameron and Blandford recently proposed a simplified method for assessing the selectivity of proteinuria in patients with nephrotic syndrome. The ratio of the clearance of IgG to the clearance of transferrin correlated well with response to immunosuppressive therapy.

The selectivity indices of 24 patients (20 adults, 4 children) with heavy proteinuria (2.0 gm./day) were determined prior to the beginning of immunosuppressive therapy. Histologic correlation from renal biopsy specimens was available in all cases.

Eleven patients had selectivity indices of 0.2 or less. Nine of these patients responded favorably to immunosuppressive treatment, two with a complete remission. Selectivity indices of greater than 0.2 were found in 13 patients. Only five of these patients responded to treatment.

No relationship between renal disease and the selectivity index could be demonstrated. The correlation between the histologic diagnosis and response to treatment was not as good as that comparing the selectivity index and response to treatment. It is suggested that the selectivity index is of value in the selection of patients with heavy proteinuria for immunosuppressive therapy.

* * *

Scleroderma Kidney, A Spectrum Of Pathology

Donald G. Vidt, M. D., Sharad D. Deodhar, M. D., and Abel Robertson, M. D.

From the Cleveland Clinic Foundation, Cleveland, Ohio

Renal involvement in scleroderma has long been considered a form of rapidly progressive renal insufficiency with associated severe hypertension. Five

patients with progressive systemic sclerosis were recently studied with renal biopsies. Tissue for immunofluorescent studies and electron microscopy were available in all cases. Four patients have been followed for periods up to 11 months after renal biopsy. Two of the four patients have arterial hypertension, which is well controlled with medication. One patient died with malignant hypertension and progressive renal failure five weeks after renal biopsy.

Renal morphologic changes were quite varied, and pathologic differences were noted in each case. One case demonstrated the changes of malignant nephrosclerosis. Fibrinoid change was noted in small arteries, and immunofluorescent studies demonstrated deposition of gamma globulin and complement in the walls of small arteries. There were extensive glomerular changes with hyperplasia of mesangial and juxtaglomerular cells. One case showed only minimal thickening of glomerular basement membrane under electron microscopy and demonstrated no deposition of gamma globulin or fibrinogen. The remaining cases demonstrated variable degrees of vascular or glomerular involvement with focal deposition of gamma globulin seen in the glomeruli in two instances.

It is concluded that the renal morphologic changes seen in progressive systemic sclerosis are of variable distribution and severity. These changes may be present in the absence of clinically evident renal failure and in the absence of arterial hypertension.

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The Role of Chronic Hemodialysis in the Management of End Stage Renal Disease

Victor Vertes, M. D., F. A. C. P.

Director, Division of Medicine, The Mt. Sinai Hospital of Cleveland University Circle, Cleveland, Ohio

As part of a comprehensive program for the management of patients with end stage renal disease, The Mt. Sinai Hospital of Cleveland has operated a 10 bed Chronic Dialysis Center since May 1, 1966. To date, 34 patients have been treated with twice weekly hemodialysis, either as a means of permanent maintenance or in preparation for renal transplantation. The procedure was uniformly effective in correcting biochemical abnormalities in these individuals. However, long term chronic hemodialysis was found to have certain specific drawbacks.

First, in only 13 of 20 patients so treated could total rehabilitation be achieved. Second, a number of medical complications were documented. They include one patient with metastatic calcification, seven patients with x-ray evidence of secondary hyperparathyroidism, five patients with hepatitis, and ten patients with sensory or motor neuropathies.

Psychiatric problems were also encountered and the ability of patients to cope emotionally with the need for twice weekly treatment was found to be a significant factor in the results of therapy. Although hemodialysis can be successfully employed in a number of carefully selected patients for long term treatment, it appears that in the overall problem of the management of end stage renal disease, its most suitable role is in the management of patients prior to renal transplantation.

* * *

Menetrier's Syndrome — A Protein Losing Gastropathy with Spontaneous Remission

Jerome R. Berman, M. D., F. A. C. P., and Earl L. Spiegel, M. D.

From the Gastric Laboratory, University of Cincinnati, and The Jewish Hospital, Cincinnati, Ohio

Menetrier's Syndrome, a form of giant hypertrophy of the gastric mucosa, was originally described in 1888. One of the cases reported in Menetrier's original paper was that of a protein-losing gastropathy.

We recently had the opportunity to study a 41 year old man who exhibited giant hypertrophy of the gastric rugae. Total serum proteins were below 4 grams during his initial hospitalization. Chromium-51 studies revealed loss of protein through the gastrointestinal tract. Gastroscopy was consistent with giant hypertrophic gastritis. Gastric photographs were obtained.

After a period in the hospital, a remission of clinical symptoms occurred and the patient was followed as an outpatient. After two months, the serum proteins returned to normal levels. After four months he was readmitted to the hospital for repeat of his previous studies. At this time his Chromium-51 tagged albumin studies revealed no abnormal loss of protein. His serum proteins had returned to normal. Gastroscopy was repeated and the giant hypertrophy was again observed.

This patient represents an interesting variation of a little understood abnormality.

* * *

Hepatic Cholesterol Ester Storage Disease

Leon Schiff, M. D., F. A. C. P., William K. Schubert, M. D., A. James McAdams, M. D., Earl L. Spiegel, M. D., and James F. O'Donnell, Ph. D., Cincinnati, Ohio

Cholesterol ester storage disease has been demonstrated in a brother and sister whose livers were orange in color and showed excessive deposition of cholesterol ester. Hepatomegaly, otherwise asymptomatic, had been present for years. Liver function tests were normal. Both subjects exhibited abnormal serum bile acid patterns with a disproportionate increase in chenodeoxycholic over cholic acid with a reversal of the trihydroxy-dihydroxy ratio (T/D). Electron photomicrographs demonstrated large numbers of electronlucent vascuoles frequently distorted

by angular crystal-like projections presumably cholesterol ester.

Similar bile acid abnormalities and hepatomegaly were demonstrated in four of five siblings; while similar bile acid changes only were found in the father and paternal grandfather. In three siblings, the liver appeared grossly normal but showed minimal histological and ultrastructural changes suggestive of a similar inherited defect.

Periportal fibrosis and early septate cirrhosis were associated findings; the relationship of these to the deposition of the hepatic cholesterol ester or to the abnormal serum bile acid pattern remains undetermined.

Attempts are still being made to elucidate the mechanism of the liver disease present. Increased synthesis of cholesterol by the liver or the small intestine or a defect of hepatic cholesterol esterase activity do not appear to be responsible for the accumulation of the cholesterol esters in the liver. The finding of a low cholesterol content in the gall bladder bile suggests a defect in the excretion of cholesterol into the bile.

* * *

Various Parameters in the Evaluation of the Presence or Absence of Liver Metastases

Agnes J. Aves, M. D., Marie H. Manno, M. D., and John B. Hill, M. D. (Associate)

From The Western Pennsylvania Hospital Pittsburgh, Pennsylvania

Since the presence or absence of liver metastasis is often of prognostic and therapeutic importance in the patient with cancer, a study was undertaken in an attempt to determine the most sensitive clinical method of determining the presence of liver metastases. An attempt was also made to see if there is a particular pattern of clinical studies distinctive for certain histologic types of tumor within the liver. Seventy-two cases were studied in whom a histologic diagnosis of the liver was available in addition to the radioisotope$_{79}$ Au.^{198} liver scan, and liver function tests.

In our series, the radioisotope liver scan was the most sensitive indication of liver metastases. It gave a positive scan accuracy of 91 per cent. Surprisingly, the alkaline phosphatase was abnormal in only 64 per cent of those cases with histologic evidence of tumor. The Bromsulphalein® (BSP), serum glutamic pyruvic transaminase (SGPT), serum glutamix oxaloacetic (SGOT), lactic acid dehydrogenase (LADH), bilirubin, and a clinically enlarged liver were less accurate and gave a high frequency of false positive and false negative results.

Scans with a defect 2.5 cm. and above all had abnormal chemical profiles and all had histologic evidence of liver metastases. Scans with multiple small defects and highly suspicious of tumor were found in both histologically positive and negative cases. Chemical liver function tests were of no help in determining whether tumor was present in a patient with this type of scan.

In only one type of tumor did there seem to be a characteristic clinical pattern. The cases of carcinoma of the pancreas with liver metastases all had an abnormal chemical profile, an enlarged liver, and a liver scan which is only suggestive of tumor, and often false negative for tumor.

* * *

Diagnosis of Colon Cancer in the Asymptomatic Patient

David H. Greegor, M. D., F. A. C. P., Columbus, Ohio

Twenty-one hundred case records of routine physical examinations performed in an internist's office were surveyed to determine the best method of detecting carcinoma of the colon in the asymptomatic patient. Seven cases of unsuspected carcinoma and one malignant polyp were detected. The seven cancers were all beyond the range of the sigmoidoscope, but all had positive tests for occult blood in at least one out of three stool specimens. This finding led to the preparation of an easier and less offensive method for multiple stool examinations. Patients were given slides of guaiac impregnated paper to take home and prepare multiple slides from three separate evacations. Slides were then tested in our office. Those who had at least one positive were given a barium enema examination. Out of the first forty positives, four carcinomas were detected — one suspected and three unsuspected. We are now attempting to screen all our asymptomatic examinees with, in addition to sigmoidoscopy (whose limitations are legion), multiple stool examinations for occult blood followed by barium enema on the positives.

* * *

Gastric Mucosal Web in Adults

Anastacio Hoyumpa, Jr., M. D., Yahya Berkmen, M. D., and Benjamin Felson, M. D.

From the Gastric Laboratory, Department of Internal Medicine, and Department of Radiology, University of Cincinnati College of Medicine, Cincinnati, Ohio

Gastric obstruction may be caused by a mucosal web extending across the distal stomach. Since the anomaly is surgically correctable, its recognition is important. Four proven and six probable cases are presented to emphasize the clinical, radiographic, and gastroscopic features.

Postprandial abdominal fullness or pain, vomiting, anorexia, nausea, and weight loss were experienced by the patients. Solid foods were poorly tolerated and eventually the diet was limited to liquids.

Symptoms were present for two to 40 years, but the more recent onset of vomiting led to hospitalization.

The gastrointestinal series showed a characteristic defect across the antrum, which was sometimes mistaken for spasm, stenosis, or peptic ulcer deformity. Gastric retention was present.

Three of the patients were operated on for gastric obstruction. In each one, a thin web with a small central opening was found 1.0 to 1.5 cm. proximal to the pylorus. In the fourth patient, the web was seen at the pylorus and was an incidental autopsy finding. In all four patients the opening was less than 7 mm. in diameter. Microscopically, there was a layer of mucosa and submucosa on each side of the web with a layer of muscularis mucosa between.

The six unproved cases showed clinical and roentgen findings similar to the proved ones. In three out of four patients gastroscopy revealed features consistent with a mucosal web.

Gastric mucosal web is probably a congenital anomaly. Since all the patients were edentulous, poor mastication resulting in large food particles may be responsible for the late onset of symptoms. Progressive narrowing of the opening has not been demonstrated.

The Role of the Gastrocamera in Diagnosis

Henry B. Friedman, M. D., Benjamin H. Sullivan, Jr., M. D., F. A. C. P., and Charles H. Brown, M. D., F. A. C. P.

From the Department of Gastroenterology Cleveland Clinic, Cleveland, Ohio

The Olympus GT5 gastrocamera can be used to photograph almost all of the interior of the stomach safely, speedily, and with little discomfort to the patient. It was originally proposed as a survey instrument, but we have employed it to supplement other available diagnostic measures in patients suspected of having gastric disease.

In a two-year period 133 examinations have been made; 22 gastric ulcers, four marginal ulcers, 20 carcinomas of the stomach, and 19 patients with gastritis have been identified. The instrument is less effective than gastroscopy for prepyloric and antral ulcers. The gastrocamera can be manipulated to photograph the cardia and the upper portion of the stomach, an area blind to gastroscopy and difficult to examine by x-ray. The wide angle lens makes sharply defined photographs covering large areas of stomach and permits accurate orientation of lesions.

The gastrocamera examination is made to improve diagnostic accuracy in patients with intragastric lesions.

RHEUMATIC FEVER IN SIBLINGS. — Most attacks of rheumatic fever have only one or two major clinical manifestations. The possibility that the host is genetically predisposed to individual manifestations was explored by determining whether siblings with rheumatic fever tend to have the same manifestations and sequelae.

Sixty-seven sibling pairs were studied. Data of the clinical manifestations during the first attack and of the subsequent sequelae were collected for each member "blindly." The concordance of manifestations and sequelae within sibling pairs was then evaluated statistically.

Concordance was significant for chorea (p less than 0.01) and for joint involvement (p less than 0.05). Cardiac involvement was concordant when gauged by the presence of residual heart disease (p less than 0.05) and discordant when gauged by the less reliable method of retrospective diagnosis of carditis.

Biases, infectious agent and environment were found to be unlikely reasons for the concordance of manifestations. The exclusion of these factors suggests that the concordance is caused by genetic variation. — Mario Spagnuolo, M. D., and Angelo Taranta, M. D., New York City: *The New England Journal of Medicine,* 278:183-188, January 25, 1968.

Surgical Treatment of Decubitus Ulcers In Paraplegic Patients

SOL DAVID BRAVER, M.D.

SINCE THE Second World War, great strides have been made in the treatment of decubitus ulcers in patients with spinal cord injuries. These patients can now be kept alive for a more nearly normal life span due to the antibiotics, nursing care, good nutritional management and surgical management by the neurosurgeon, urologist, and plastic surgeon. Up until papers by Gelb,[4] Griffith and Conway,[3] surgical treatment of decubitus ulcers in paraplegics was concerned with initial closure of the ulcer and little regard for the possibility of a recurrence. These men presented a method of treating decubiti surgically in such a fashion as to prevent their recurrences. Kirk[5] reported there were 1,400 paraplegics as a result of wounds incurred in World War II. Seventy-five per cent of these had decubitus ulcers on return to the United States.

Surgical closure of decubitus ulcers in paraplegic patients was first performed by Lamen and Alexander,[6] during the Second World War. Following this, many reported surgical closure of these ulcers, using rotation flaps and skin grafts. An important advance was made by Blocksman, Kostrubala, and Greeley[1] in 1949, when they suggested the removal of the bony prominence underlying the decubitus ulcer. They specifically recommended subtotal ischiectomy and obturator internus muscle flaps for ischial ulcers. Conway, et al,[2] and Gelb[4] suggested the use of large rotation flaps so that, should a recurrence develop, one could then again raise the flap and rotate it further.

Pathology

In the decubitus ulcer, continued pressure over bony prominences produces multiple thrombosis of small vessels resulting in necrosis. The necrotic tissue either sloughs or is debrided, and an ulcer results. As the infection advances into the subcutaneous tissue, undermining develops and the underlying bony prominence may become exposed.

Submitted September 19, 1967.

The Author

● **Dr. Braver, Akron, specializes in plastic surgery, and is on the Senior Staffs of City, General, Childrens, and St. Thomas Hospitals, Akron, and Barberton Citizens Hospital.**

Osteomyelitis occurs and sequestra may be extruded from the wound.

Prevention

The most important factors in the prevention of decubitus ulcers in paraplegics is good nutrition with a high protein and high vitamin intake, the use of iron and/or whole blood when indicated, and avoidance of trauma over bony prominences. The urinary tract should be well cared for and infection avoided. It may be necessary to form an ileal loop bladder. Good nursing care entails turning the patient at one hour intervals. The skin should be kept dry and clean. Bony prominences should be well padded with multiple pillows while the patient is in bed. Enemas should be given twice a week to those who require them. Passive exercises should be given daily to prevent joint stiffness and active exercises should be instituted to maintain more tone and strength in unparalyzed muscle groups. Where possible, the patient should be ambulated with braces, parallel bars, and crutches. When sitting in wheel chairs, patients should rest on a 4-inch rubber foam pad, with appropriate hollows cut to prevent pressure on bony prominences.

Preoperative Care

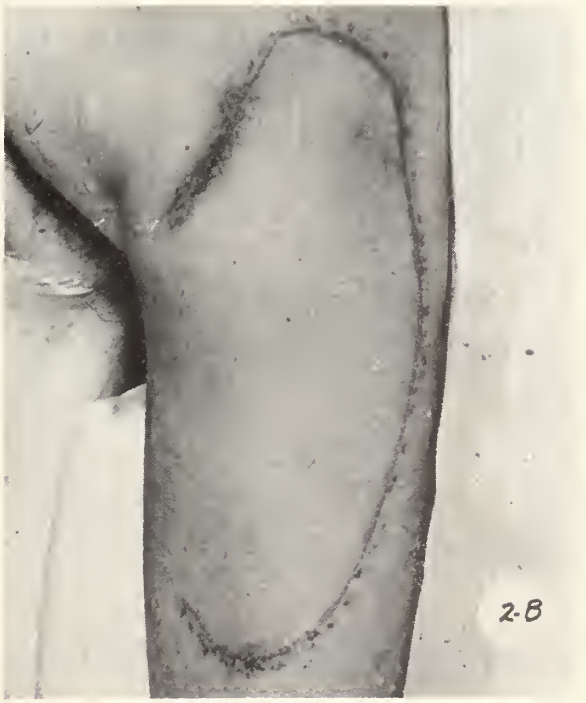
When the decubitus ulcer occurs, surgical treatment should be delayed until it is ascertained that no urinary infection or urinary calculus is present. If muscle spasms occur in the patient, one should eliminate them before surgical closure of decubitus ulcers, because spasm in the lower extremities has





Case 1. The first patient was a 19-year old boy, who sustained a spinal cord injury in an automobile accident. He presented himself with a sacral decubitus 3-inches in diameter, exposing the sacrum. Figure 1-A shows the ulcer and Figure 1-B shows the flap rotated in place to cover the defect, with some sutures remaining.



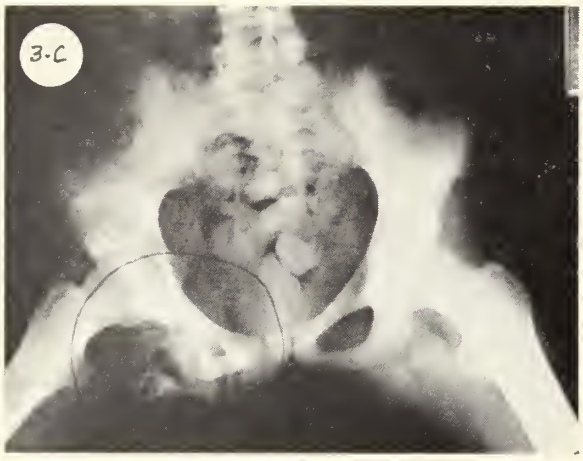


Case 2. The second case was that of a patient who also sustained a spinal cord injury due to an automobile accident. He developed a decubitus over the right greater trochanter. Figure 2-A shows the decubitus and Figure 2-B shows the flap rotated in place to cover the defect.





Case 3. The third patient is a 17-year old girl, who was shot in the abdomen and sustained a spinal cord injury. She developed an ischial decubitus ulcer, which is shown in Figure 3-A. Figure 3-B shows the large biceps femoris muscle flap rotated after removing the ischium. Figure 3-C shows an x-ray of the pelvis of this patient preoperatively and 3-D shows an x-ray postoperatively showing how much of the ischium had been removed.





caused separation of the wound edges after repair of the ulcer. Monro[7] first advocated anterior rhizotomy to eliminate spasticity. Other means of eliminating muscle spasms in the lower extremities are: subarachnoid alcohol block, obturator nerve section, and femoral nerve crush. Demerol® has also been used to control spasms but has a disadvantage of causing addiction.

Surgical Treatment

The ulcer and surrounding scar tissue must be excised. The underlying bursa must be excised, if present, and the underlying bony prominence must be removed. In sacral decubiti, the posterior table of sacrum must be removed; in trochanteric decubiti, the greater trochanter of the femur; and in ischial decubiti, the entire ischium from the symphysis pubis to the rim of the acetabulum must be removed. Hemostasis must be obtained during surgery. Where large holes have been created by the above resection, a muscle flap should be used to fill the hole and provide a pad of soft tissue. For ischial ulcers, one can use the biceps femoris muscle, which is divided in its insertion and turned on itself. A large flap of skin and fat should be rotated. It should be designed in such a fashion that there is no question

of impairment of the circulation and so that the scars will not be subjected to repeated trauma. Large flaps are used so that, in the event of recurrence, the flap can be rotated again. The donor site of the flap may be closed by split thickness skin grafts or by mobilizing adjacent tissue.

Case Presentations

The most common sites of decubitus ulcers in paraplegics are the sacrum, the greater trochanters, and the ischi, in that order. I would like to present four patients. (See descriptions with illustrations.)

Summary

We have narrated the history of the treatment of decubitus ulcers in paraplegic patients, described the pathology and a regimen in order to prevent their recurrence. We have also described the preoperative care, the surgical treatment, presenting some cases of the more common decubiti which occur in paraplegic patients.

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Case 4. I would also like to include a rather unusual case. This 29-year old man sustained a spinal cord injury as a result of a gun shot wound and developed a large decubitus ulcer involving most of his buttocks and the right hip joint. Previously, this man had had an above-knee amputation of both legs done elsewhere. Figure 4-A shows the patient before operation. Here, we did a left hemipelvectomy in order to get enough flap to cover the deficit, as well as to remove the infected bone. Figure 4-B shows the final result.

Ohio Psychiatric Association

Abstracts of Papers Presented at Annual Meeting

THE annual meeting of the Ohio Psychiatric Association, and The Section on Nervous and Mental Diseases of the Ohio State Medical Association was held in Columbus on May 17 and 18, 1967. Since all the presentations are not considered suitable for full reproduction in this *Journal*, abstracts of some selected papers are presented for the information of the membership of the OSMA. One of the papers has already been presented in the September 1967 issue.[1] These abstracts were edited by Dr. James R. Hodge of Akron.

* * *

The Psychiatrist as a Consultant to the Community

Arthur F. Ritchey, M. D., *Cleveland*

Modern psychiatrists have inherited a "long and largely discouraging" number of traditional beliefs and treatment methods, from the primitive medicine men, through medieval Christianity with its methods of ridding people of evil spirits, through Freudian sexual theory and guilt. The author believes that these traditions often impair the ability of psychiatrists to do an adequate job as a consultant to communities and to community agencies.

The author deplored "superconfidentiality" and how this prevents the psychiatrist from communicating adequately about the patient to the family, the physician, or the community agency. He feels that this is unnecessary and that it also contributes to feelings of guilt in patients and their families. Another barrier to effectiveness is psychiatric jargon. He feels that the psychiatrist hides behind jargon and "superconfidentiality" to conceal his own uncertainty.

The author conducts conferences to which everyone who is a major figure in the patient's life is invited, so everyone concerned knows exactly what is going on. This includes parents, physicians, teachers, and case workers. He also emphasizes that recommendations by the psychiatrist must be realistic and capable of being carried out in that sense.

* * *

A Comprehensive Medical, Social, Psychiatric Facility for Children

Arthur F. Ritchey, M. D., *Cleveland*

In the spring of 1957, Cuyahoga County opened a new facility for children: The Bessie Benner Metzenbaum Children's Center. The center has five residential wings giving temporary residential care for children of both sexes from preschool age through adolescence. So far as is known, this is the first facility with complete coordination of all the services — medical, dental, social, educational and psychiatric — which are needed to help all of these children in *one single Center*. There is a medical wing, dining room, school wing, and recreational wing.

One of the most important services offered is a twenty-four-hour-a-day emergency homemaker service provided by the County Division of Child Welfare. This provides emergency and short term care by parent substitutes and thus avoids long term institutional care in many cases, and also spares these children the traumatic disruption of being hastily removed to publicly provided and strange "shelter." When it is necessary for a child to be admitted to the Center, every possible effort is made to return him promptly to his own family. This is facilitated by professionals of many skills, such as psychiatrists, psychologists, case workers, homemakers, and teachers, all working together with the child and his family. Social-psychiatric work with the family as well as with the child is considered mandatory.

Children do not remain at the Center for longer than 90 days. Long-term placement, the extended separation of a child from his family, is the very last resort with some of these cases. It is felt that this team approach to family therapy is more effective and less expensive than more traditional methods of social work and psychiatric treatment.

* * *

Success and Failure in the Adult Day Unit

Irving M. Rosen, M. D., *Cleveland*

Many reports, mostly glowing, have appeared in the literature recently about experiences with "day care units" attached to psychiatric hospitals. Several years' experience in such units has convinced the author that such units cannot replace inpatient facil-

ities, especially for confused, assaultive, or suicidal patients. Instead, the day care unit extends our offering to patients who have not been sick enough to be hospitalized but have not responded to outpatient treatment, and especially to patients who require rehabilitation and treatment after hospitalization. The day care unit is a difficult place in which to work. The patients are generally in the "intermediate" stages of illness for which our armamentarium of psychotherapy, drugs, or electric shock treatment is least effective and least able to be prescribed specifically. There is continual experimentation with new programs and new ideas. There is the necessity for working as a team in spite of the complaining and manipulating by certain patients. Reality problems of transportation, physical illness, home problems, and staffing problems must constantly be handled. Advantages to the day care unit are that the patients remain in the community and they are seen as total personalities. Further, a reconstructive program rather than a crisis-oriented program is administered.

The day care unit is generally not suitable for chronic schizophrenic or psychopathic patients, and it should not be used for the milder cases which may be treated as outpatients. It is a favorable place to treat severe neurotic, character disordered, borderline psychotic, mildly retarded and minimally brain damaged, adolescents over age 15, and adults over 60 years old.

* * *

The Psychiatrist as a Consultant to the Clergy

The Rev. Robert A. Blees, *Columbus*

In his presentation, Reverend Blees focused his attention on interdisciplinary cooperation, interdisciplinary communication and language, and training in pastoral counseling.

Our professions should aid and complement each other to help develop mature personalities and to create an environment conducive to maximum growth, maximum security, and maximum creativity.

He defined some theological terminology to which psychiatrists have objected because they could not understand it. For example, he described "being possessed of the Holy Spirit" as referring to an individual who is aware that he has the inherent capacity to meet life and the ability to solve his own problems. Pragmatically, this differs little from the psychiatric concept of "ego." "Sin" is a theological concept now used to describe any behavior which separates or isolates an individual from meaningful relationship with another individual. "Forgiveness" does not mean that the sin has been erased; it means that in spite of the hurt and pain of this interaction one is still willing to try to reestablish a relationship. "Forgiveness" is similar to the "acceptance" of the behavioral sciences. Whenever the sin is too great and the persons cannot forget, "atonement" takes place when a third person (psychiatrist, pastoral counselor) bridges the gap with love and understanding so that those isolated are able to reach out to reestablish a relationship.

The American Association of Pastoral Counselors has now established qualifications which a clergyman must meet to receive accreditations as a pastoral counselor. In addition to academic training, these criteria include counselling supervision by a psychiatrist, a psychiatric social worker, and a clinical psychologist. The Pastoral Counselling Center at First Community Church, Columbus, is accredited by this organization.

* * *

The Development of the Portage Path Community Mental Health Center and the Mental Health Council of Summit County

Basil D. Roman, M. D., *Akron*

When Federal funds became available for financing the building and staffing of community mental health centers, a state wide mental health survey was made by a "citizens committee." At least in Summit County, there was no follow through after the survey was completed, and the slack was taken up by a group of interested laymen who were able to get four agencies to collaborate in the development of the Portage Path Community Mental Health Center. These agencies are Akron General Hospital which has a psychiatric unit, the Akron Child Guidance Center, the Summit County Mental Hygiene Clinic, and Children's Hospital. They have agreed to a program of collaboration to provide mental health services to an area of approximately one third of Summit County, and Akron General Hospital received a grant to expand its psychiatric unit to help provide this service. Interestingly, another one third of the county is offered service through a second Center (Fallsview), but the remaining one third has no service offered at all and none is even in the planning process.

Professionals were rarely consulted during the above planning, perhaps because there were no strong professional organizations to ask. The Summit County Medical Society in conjunction with the Northeast Ohio Psychiatric Association called a conference on the mental health needs of the community. Out of this meeting there was created the Mental Health Council of Summit County, an interdisciplinary group of professionals in the field of mental health such as psychiatrists, psychologists, physicians, psychiatric social workers, other social workers, ministers, probation officers, and lawyers. Their primary purpose was not to conflict with or compete with the citizens group, but to share information and communication among themselves;

to offer consultation and advice to any professional or any citizens group which requested it; to make studies of local situations on its own and for its own use; and to prod citizens groups to action in areas where only citizens groups could work. This organization meets three times yearly and other times as necessary.

Since its inception in 1966, the council has been recognized by the medical society and the United Community Council, has made a study on the problems of emergency psychiatric services in the county and distributed a report of this study to its members (This report later served as the basis for a series of television programs about this problem), was called into consultation by the United Community Council regarding the development of a "Halfway House" for psychiatric patients, has sent a representative to the Citizens Committee on Mental Retardation, and has submitted to the county commissioners a list of recommendations for appointments to the County Board of Mental Health and Retardation.

It is felt that this is a unique organization which has already demonstrated its usefulness and probably should be copied in many counties throughout the state and nation. Emphasis is not placed on obtaining federal funds or influencing state legislation. Emphasis is placed on what the community can do for **itself**, especially by the professionals in it.

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ART IN PRACTICE OF MEDICINE. — It has been said that preoccupation with the medical record and the computer leads to neglect of the "humanitarian" side and the "art" of medical practice. The most humanitarian thing a physician can do is to precisely know what he is doing, and make the patient as comfortable as he can in the face of problems that he cannot yet solve. There have been major humanitarian and sociologic failings in medicine, but almost all of them can be attributed to our poor behavior as scientists as we have dealt with problems out of context and ignored data relevant to good medical care. It is true that no system will make one kind, thoughtful or sympathetic, but to say that the art of medicine is not dependent on a great deal of discipline and order is to miss perhaps the true understanding of what underlines art in any form. Words of Stravinsky might be applied to our situation: "Human activity must impose limits upon itself. The more art is controlled, limited, worked over, the more it is free." If we accept the limits of discipline and form as we keep data in the medical records the physician's task will be better defined, the role of paramedical personnel and the computer will be clarified, and the art of medicine will gain freedom at the level of interpretation and be released from the constraints that disorder and confusion always impose. — Lawrence L. Weed, M. D., Cleveland: *The New England Journal of Medicine,* 278:652-657, March 21, 1968.

Clinical Note

Wallet Hip

CHARLES T. WEHBY, M.D.*

PRODROMAL diagnostic criteria present a challenge to physicians in general practice. In some instances, similar to the subject to be discussed here, a simple solution to a particular problem is discovered and, because of its relatively insignificant contagious or disability characteristics is left hidden from the medical profession. Lest this transgression of the Hippocratic oath continue to exert its influence, I herewith present a simple method to relieve a painful condition of the left hip (wallet hip) which, of late, has increased in importance and degree.

Necessity may be the mother of invention, but musculoskeletal symptoms are the children of etiologic complaints that often tax the ingenuity of physicians. In the peculiar world of general medicine, where strange and oftentimes mild complaints abound before some finally crystallize into a definite disease entity, the physician is confronted with situations that lend themselves admirably to experimental pursuits. It was this atmosphere which precipitated an inquiry into the cause of *left* hip pain of an ephemeral nature, which affected a select group of individuals.

Because of the disability characteristics mentioned above, the patient usually only casually refers to his symptoms, oftentimes while being treated for another complaint. He notes frequently left hip pain on rising from a sitting position which, if he does not operate a moving vehicle regularly, completely subsides in one week. However, if it is his lot to drive regularly, the symptoms are in direct proportion to the length of time that he exercises this privilege. The complainant is always (a) the operator of a moving vehicle and, after questioning, admits that (b) he always carries a wallet in his left hip pocket.

Physical examination reveals pain in all dimensional movements of the left hip. There is always point tenderness over the left greater trochanter. Laboratory, neurologic, x-ray signs, and gross abnormalities are conspicuous by their absence.

An analysis of the etiologic basis of the left hip pain in this particular group reveals a simple but predictable basis for the symptom complex. Modus operandi: The increased thickness of the wallet, due to the containment therein of innumerable identifying cards and currency, has fashioned an ideal instrument for an experiment which would burden the inguenity of hallowed wall experimenters. This villain, together with the innate tendency of vehicle operators to lean to the left side, in a more or less relaxed and slouched position, results in a continuous tamponade against the left greater trochanter, with resulting torsion effect on the ligaments and muscles positioning the neck and head of the femur to the acetabulum. It takes no imagination to see that this constant trauma will result in symptoms which have a cause and effect basis. In every case presenting symptoms of "wallet hip" studied by me, the symptoms were completely and permanently relieved by merely removing the wallet from its usual position.

Although this contribution is related to Newtonian and Archimedian principles like fog is to the sea, it does prove that the observant physician, by simple analysis can exercise his traditional role of ferreting out causes and cures for people that he serves.

*Dr. Wehby, Cincinnati, is a member of the Medical Staff, Good Samaritan Hospital.

THE GENERAL MEDICAL JOURNAL has a useful place in clinical medicine. It fulfills three main functions: to record what is new, to educate and to provide a forum for discussion. But in this age of specialization and increasing clinical isolation perhaps its greatest task is just to keep doctors talking to each other in the same language. — Martin Ware, M. B., F. R. C. P., London: *The New England Journal of Medicine,* 278:3-5, January 4, 1968.

Heart Page

Peripheral Vascular Disease

VI. Sudden Arterial Occlusion

RAY W. GIFFORD, JR., M.D.

FEWER than 50 per cent of patients with sudden occlusion of a major artery to an extremity will survive with an intact limb without appropriate treatment. The prognosis is better for survival of an upper extremity than for a lower extremity. The more proximal the site of occlusion, the worse the prognosis.

Sudden occlusion of a peripheral artery may be caused by an embolus or by acute thrombosis, usually at the site of an atherosclerotic plaque. More than 95 per cent of peripheral emboli arise from the left atrium or left ventricle, and they almost inevitably lodge at bifurcations of the artery. Recent myocardial infarction, mitral stenosis, and chronic congestive heart failure from any cause are the cardiac lesions that most frequently predispose to peripheral embolization. Atrial fibrillation, though often present, is by no means a prerequisite. Occasionally, emboli arise from the wall of an atherosclerotic aorta or an aneurysm.

Acute thrombosis of a peripheral artery may be the first sign of atherosclerosis obliterans, or it may punctuate the course of symptomatic atherosclerosis obliterans. Traumatic thrombosis or idiopathic thrombosis is sometimes responsible for sudden arterial occlusion in an extremity. Because of the different therapeutic implications, the clinician should be aware that sometimes sudden arterial occlusion of an extremity is the first symptom of dissecting aneurysm of the aorta.

When arterial occlusion occurs abruptly in the presence of heart disease, embolus should be suspected; when sudden arterial occlusion occurs in the absence of heart disease or arterial aneurysm, thrombosis in situ is usually responsible, whether or not there is a previous history of chronic occlusive disease.

Abrupt onset of pain in the affected extremity is the first manifestation of sudden arterial occlusion in fewer than 50 per cent of cases. Many patients experience no pain whatsoever and simply describe numbness, paresthesia, or coldness of the extremity. Paresis is usually a late manifestation. In some cases, sudden onset or abrupt worsening of intermittent claudication is the only clinical manifestation of acute arterial occlusion. Characteristic physical findings include absence of arterial pulsations that were previously known to be palpable, pallor or cyanosis with coolness and hypesthesia of the skin, and collapsed superficial veins. Usually the level of demarcation between normal skin proximally and cool, pale, hypesthetic skin distally in the extremity affords a clue to the level of arterial occlusion. Edema is invariably absent unless there is concomitant venous occlusion or congestive heart failure.

It is axiomatic that to be successful, treatment must be promptly instituted. The extremity should be wrapped in a protective dressing and placed in a dependent position. Heparin should be administered intravenously promptly unless a dissecting aneurysm is suspected. The anticoagulant effect of heparin can be neutralized with protamine sulfate immediately before operation if necessary, or if surgical treatment is contraindicated a coumarin anticoagulant can be substituted for heparin after a few days. To afford vasodilatation, ethyl alcohol can be given orally (as whiskey) or intravenously. Alternatively, papaverine 30 to 60 mg. or tolazoline hydrochloride (Priscoline®) 25 to 50 mg. may be given intravenously or intra-arterially proximal to the site of occlusion. Injections to anesthetize paravertebral ganglia should be avoided in heparinized patients because of the danger of hemorrhage.

While appropriate medical treatment, initiated early, will salvage most limbs, the functional result is better if the embolus or thrombus can be removed surgically — or in some cases of acute thrombosis if a bypass graft is implanted. Unfortunately, most patients with emboli also have serious heart disease that increases the risk of any operation; therefore, the clinician must weigh the risk of a limbsaving embolectomy against the risk of a major amputation if it is not done. By using the balloon (Fogarty) catheter it usually is possible to remove nonadherent emboli or soft thrombi from the terminal aorta, or from the popliteal and tibial arteries, through a femoral arteriotomy under local anesthesia, with minimal risk. While results are best if operation is performed within a few hours after onset of symptoms, successful embolectomy has been accomplished after several days. Anticoagulant therapy should be continued indefinitely postoperatively to prevent recurrent embolization or thrombosis.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio.

Proceedings of The Council...

In Columbus at Headquarters Office, March 30-31
Matters Considered and Actions Taken at Meeting

A MEETING of The Council of the Ohio State Medical Association was held in the headquarters office, Columbus, March 30-31, 1968. All members of The Council were present except the following: Dr. F. T. Merchant, Marion, Councilor of the Third District; Dr. Robert N. Smith, Toledo, Councilor of the Fourth District; Dr. E. R. Westbrook, Warren, Councilor of the Sixth District. Others attending the meeting were: Mr. Roger Smith, Toledo, OSMA Legal Counsel; Dr. John H. Budd, Cleveland, Chairman, Ohio delegation to the AMA; Dr. Robert E. Tschantz, Canton, AMA delegate and chairman of the OSMA-OMI Liaison Committee; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, and Moore of the OSMA staff. Also present at the meeting on Saturday was Dr. William A. Newton, Jr., Columbus, a member of the Ohio Cancer Coordinating Committee.

Minutes Approved

The minutes of the meeting of The Council, held February 17-18, 1968, were approved by official action.

Miscellaneous Communications Presented

Dr. Howard presented communications from Dr. Joseph A. Freiden, Cincinnati, acknowledging AMA-ERF funds for the University of Cincinnati; Dr. Lloyd E. Larrick, Cincinnati, praising Mr. Gillen's handling of the Second Ohio Conference for Medical Chiefs of Staff in Cincinnati; Mr. John W. Main, Ohio Department of Public Welfare, concerning billing procedures in welfare cases.

Also discussed by The Council was a letter from Mr. Robert B. Canary, Ohio Department of Public Welfare, to Mr. Page regarding a communication from Dr. Robert E. Sooy, Mt. Vernon, Vice-President of the Knox County Medical Society, to the Governor of Ohio.

By official action, The Council adopted a message of congratulations to Dr. Lloyd E. Larrick, Cincinnati, on his elevation to the presidency of the Ohio Hospital Association.

Membership and Financial Matters

Membership statistics were presented by the Executive Secretary.

Acceding to a request from the Summit County Medical Society, The Council waived 1968 OSMA dues for Dr. Franklin C. Kunz, Akron.

The Council ratified *nunc pro tunc* the 1967 dues of two Cincinnati Academy members who were omitted from the Academy's 1967 certification list in error. This action by Council has the effect of giving these physicians continuous membership.

The Council authorized the Auditing and Appropriations Committee to determine proper distribution of the AMA reimbursement funds connected with the collection of AMA dues.

The chairman of the Auditing and Appropriations Committee was authorized to investigate the feasibility of providing better seating facilities in the conference room.

Dr. Schultz presented a progress report of the Ad Hoc Committee to Study Membership. He was authorized to hire extra secretarial help for the processing of the study.

Future Planning Committee

It was announced that the following would serve on the Future Planning Committee, with duties parallel to a similar committee of the American Medical Association established as a result of the efforts of Ohio's AMA delegates: Dr. William R. Schultz, Wooster, chairman; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. P. John Robechek, Cleveland; and Dr. Robert E. Howard, Cincinnati.

AMA Socioeconomic Conference

Dr. Schultz reported on the AMA Socioeconomic Conference held in Chicago, March 22, 1968. He reviewed Dr. Howard's preconference correspondence, which asked for clarification of the intent of the program and the type of group practice to be discussed at the meeting. He also pointed out that a number of questions were asked about the representation of the feelings and opinions of those in the private sector of medicine. Dr. Schultz then presented to The Council the statement Dr. Howard delivered to the conference at the close of the first day. By official action, The Council voted to extend to Dr. Howard its appreciation, commendation,

and support for his correspondence before and his statement during the conference.

Secretary of HEW

A communication from Dr. Howard to the *Cincinnati Enquirer* with regard to the appointment of Wilbur J. Cohen as Secretary of the U. S. Department of Health, Education, and Welfare was brought to the attention of The Council. The Council ratified the efforts of President Howard in his opposition to the appointment of Mr. Cohen.

Councilor Reports

The Councilors reported on activities in their districts.

Dr. Richard L. Fulton, Columbus, announced that he had resigned his appointment as chairman of the Advisory Committee, Ohio State Regional Medical Program under Public Law 239.

Fall Conferences

Dates and places for the Fall District Conferences were reviewed.

1968 Annual Meeting

Exhibits — Mr. Campbell presented a progress report on the 1968 Annual Meeting, which indicated there will be a record number of exhibits — 106 technical exhibits and 66 scientific and educational exhibits.

The Council authorized carpeting for the scientific and educational exhibit area.

Program — Mr. Campbell said that a complete program of the annual meeting will be mailed to all members by April 15.

Nomination for President-Elect — The Council was advised that Robert N. Smith, M. D., Toledo, has been nominated for the office of President-Elect.

Resolutions — Resolutions filed with the Executive Secretary for presentation to the House of Delegates were reviewed.

New developments concerning Resolution No. 17 on osteopathic internships and residencies were related by Dr. Budd, who indicated that he would bring such developments to the attention of the reference committee when the hearings are scheduled.

It was brought to the attention of The Council that passage of Resolution No. 9 would require completion of a rotating internship as a prerequisite to licensure in face of the fact that rotating internships in many cases are being discontinued.

The Council instructed the Executive Secretary to work with the OSMA legal counsel to draw up some "ground rules" with regard to the preparation of resolutions and disseminate them to County Medical Societies in advance of next year's annual meeting.

Resolution No. 17 (1967), Reapportionment — Dr. Ivins presented a report of the Ad Hoc Committee on Resolution No. 17 which was adopted at the 1967 Annual Meeting. The Council authorized Dr. Ivins to summarize the report for presentation to the 1968 House of Delegates.

Substitute Resolution No. 7 (1967), Group Malpractice Coverage — A report on this resolution was accepted by The Council for presentation to the 1968 session of the House of Delegates.

New Section Authorized — In response to a request from Dr. Ralph Samson, Columbus, The Council authorized the organization of an OSMA Section on Colon and Rectal Surgery.

American Medical Association

Resignation of Delegate — The resignation of Dr. Edmond K. Yantes, Wilmington, as a delegate to the AMA from Ohio was accepted with regret.

Resolutions — A resolution calling for interim sessions of the AMA House of Delegates to be held in January or February of each year in Chicago, and asking certain other economies with regard to committees and councils of the AMA, was amended and adopted by The Council for presentation at the San Francisco meeting.

A resolution calling for the supervision by the Board of Trustees of conferences presented by the American Medical Association was approved, in principle, with instructions to Dr. Budd to prepare the final draft for submission to the AMA headquarters.

A resolution from the Omaha-Douglas County Medical Society, Omaha, Nebraska, was studied by The Council.

Federal Legislation

Mr. Edgar reported on the Murphy-Hartke-Lausche amendment, clarifying internal revenue regulations with regard to the income of nonprofit organizations, which was adopted in the Senate and is currently being considered by the joint conference committees dealing with the excise tax bill.

Mr. Page reviewed plans for the 1968 Washington visitation scheduled for June 5.

County Medical Societies

Clermont County — A proposed amendment to the bylaws of the Clermont County Medical Society was discussed by The Council. Dr. Ivins was instructed to discuss this amendment with the society on behalf of The Council and report back at the next Council meeting.

Trumbull County—A proposed amendment to the bylaws of the Trumbull County Medical Society was approved by official action.

Ohio Medical Indemnity, Inc.

In the absence of Dr. Robert N. Smith, Toledo, the chairman, Dr. Richard L. Fulton presented the report of the OMI Nominating Committee. The

(Continued on Page 601)



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Vistaril®

HYDROXYZINE PAMOATE

an antianxiety agent that serves a human need...



"The danger involved in prescribing dependency producing medication for relief of anxiety lies in the fact that we do not know in advance the dependency proneness of the individual."[1]

A woman who is undergoing the emotional stresses of the menopause may, for the first time, need an antianxiety agent. But she may also be susceptible to drug abuse.

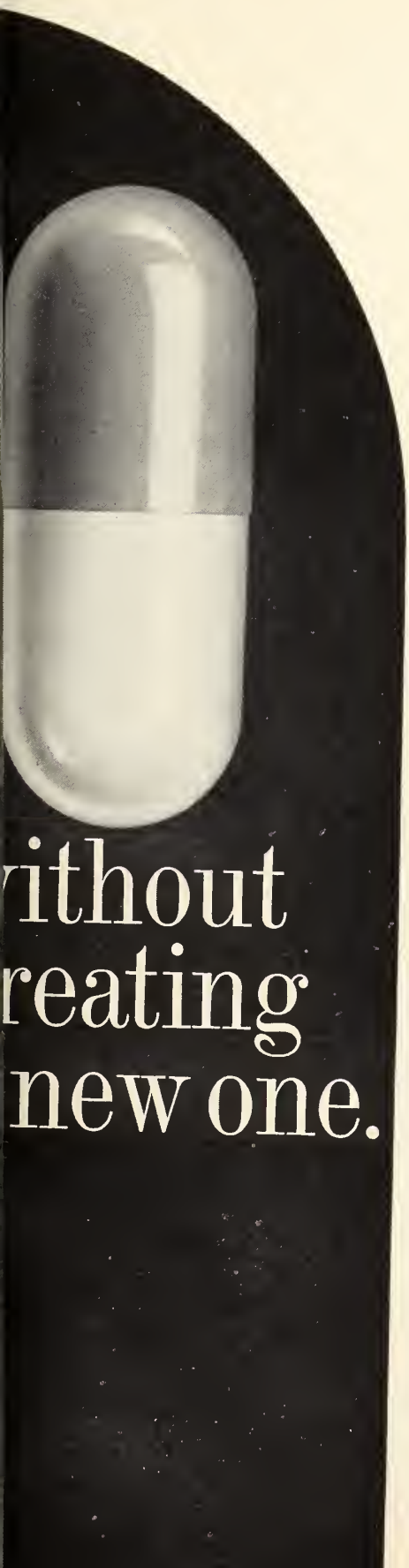
Vistaril can fulfill the need for tranquilization without creating a new need—dependency.

Vistaril calms anxiety and agitation quickly—usually begins to work in 15-30 minutes. And, in more than ten years of clinical use, after more than a billion doses to date, there have been no reported instances of dependency on hydroxyzine.

When the need for antianxiety medication is reduced or no longer exists, Vistaril dosage may be lowered or discontinued without ill effects.

Recommended starting dose, anxious menopausal patient, 50 mg. t.i.d.

With Vistaril, it is as easy to stop therapy as it is to start.



Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

The intravenous administration of this drug is not recommended for children under 12 years of age.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

References: 1. Greenhouse, H.R.: Medication and the Dependent Personality, Symposium of Non-Narcotic Drug Dependency and Addiction, The Amer. Psychiat. Assn., N.Y. County Dist. Branch, New York, N.Y., March 10, 1966.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017



burning



itching



discharge



of trichomonal vaginitis...

Flagyl®

tablets/inserts

brand of

metronidazole

brings

- clinical cures
- microscopic cures
- culture cures

For the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

Among the few patients who do not respond to Flagyl are those who may not have taken the prescribed dosage and those who may have been reinfected.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

SEARLE

Research in the Service of Medicine

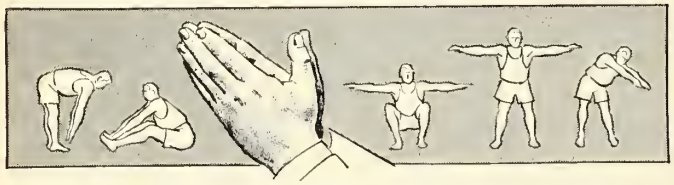
The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.
SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLÉON BONAPARTE
LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."
SOURCE: JAMA 186:65 (OCT. 5) 1963.



THE BOOK **"PRAY YOUR WEIGHT AWAY"** URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.
SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



DIET DROPOUTS ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY.**
*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

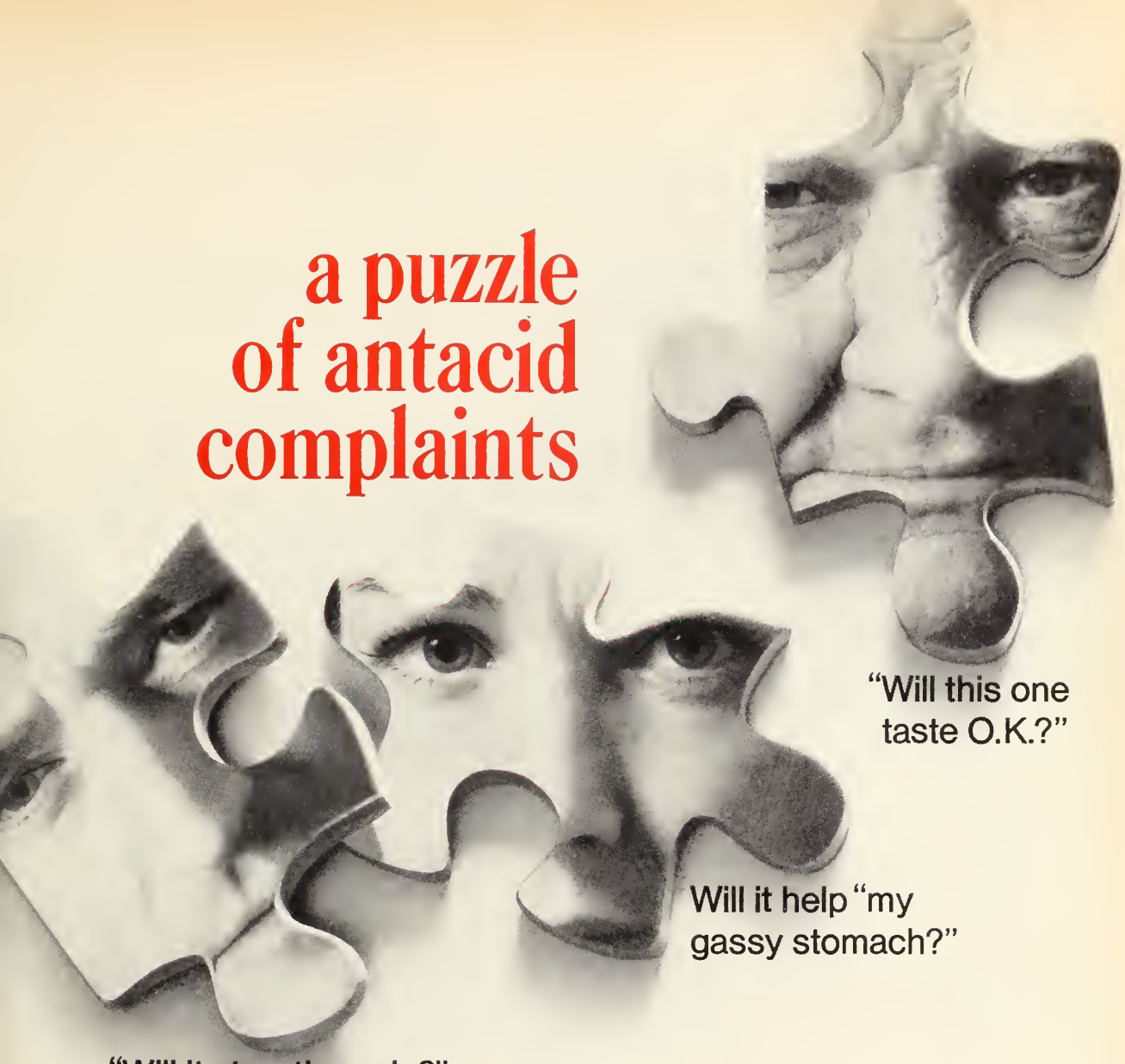
One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

a puzzle of antacid complaints



"Will this one taste O.K.?"

Will it help "my gassy stomach?"

"Will it stop the pain?"

Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition. Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

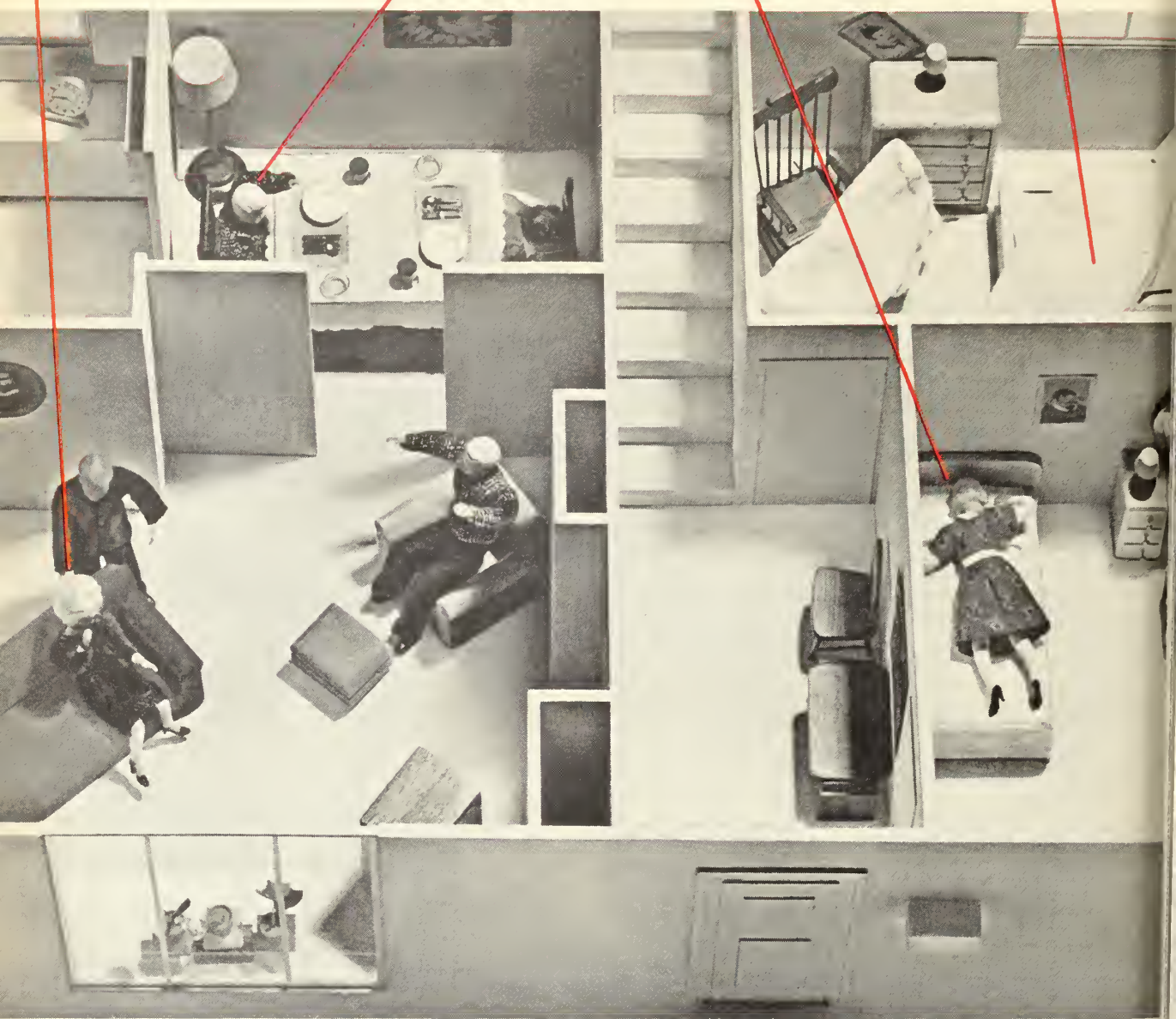
When the agitated geriatric disrupts the home...

His daughter can't please him. There is "just no living with him."

His disturbances at the table make every meal a nightmare.

His teen-age granddaughter won't invite friends home because of his outbursts.

His slovenly room and habits create more tension.



In moderate to severe anxiety...

- Mellaril helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- Mellaril often alleviates anxiety-induced somatic complaints
- Mellaril frequently helps strengthen emotional resources
- Mellaril helps the patient maintain realistic contact with environment, closer harmony with family

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atro pine, and phosphorus insecticides. Where complete mental alert ness is required, administer the drug cautiously and increas dosage gradually. In addition, orthostatic hypotension (especia ly in female patients) has been observed Epinephrine should be avoided in treat ment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism an other extrapyramidal disorders are ir frequent; drowsiness, especially in hig doses early in treatment, may occu nocturnal confusion, dryness of th mouth, nasal stuffiness, headache, pe ripheral edema, lactation, galactorrhea and inhibition of ejaculation are note on occasion; photosensitivity and othe allergic skin reactions may occur but ar extremely rare.

for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ

Before prescribing, see package insert for full product information.

68-1

committee recommended that the following be nominated and elected for the ensuing year:

Ralph L. Abernathy, Dayton; Dwight L. Becker, M. D., Lima; William T. Blair, Columbus; J. Martin Byers, M. D., Columbus; Nino M. Camardese, M. D., Norwalk; Harve M. Clodfelter, M. D., Columbus; Guerney H. Cole, Jr., Middletown; Clair E. Fultz, Columbus; Robert S. Martin, M. D., Zanesville; J. A. Meckstroth, Columbus; John R. Meek, M. D., Cincinnati;

Usher B. Redmann, Toledo; Theodore T. Reed, Jr., Pomeroy; James G. Roberts, M. D., Akron; Howard C. Sauer, Canton; Frank L. Shively, Jr., M. D., Dayton; M. M. Thompson, Jr., M. D., Toledo; Gordon M. Todd, M. D., Toledo; William A. White, Jr., M. D., Canton; Edmond K. Yantes, M. D., Wilmington; Starling C. Yinger, M. D., Springfield.

By official action, The Council **approved** the nominations presented and authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of OMI in April on all business matters coming before that meeting, including the election of directors placed in nomination by The Council at this meeting on March 30-31, 1968: Dr. Harve M. Clodfelter, Columbus, or Dr. Edmond K. Yantes, Wilmington, or Mr. Hart F. Page, Columbus.

On behalf of The Council, the President was authorized to thank the retiring directors for their past services.

Survey of Doctors Treating Welfare Patients

By official action, The Council **approved** a survey of the Ohio Department of Welfare payments for medical services to welfare patients to be mailed to 1200 medical doctors whose practice includes an appreciable number of welfare patients.

Medicare

Guidelines for Incentive Reimbursement Experiments — Dr. Tschantz reviewed "Guidelines for Incentive Reimbursement Experiments Under the Medicare, Medicaid, and Maternal and Child Health Programs," proposed in March, 1968, by the U. S. Department of Health, Education, and Welfare. This document was discussed at considerable length by The Council.

Nationwide Mutual Insurance Company — The Council then took up matters brought before it by the Nationwide Mutual Insurance Company executives concerning the problems of Medicare administration brought up by Dr. Paul S. Metzger, Vice-President and Medical Director of the Nationwide Mutual Insurance Company, on the evening of March 30. President Howard was instructed to advise the Nationwide Insurance Company to bring these problems to the attention of the individual doctor in the first instance, the county medical society in the second instance, and then if there is an impasse, to The Council of the Ohio State Medical Association.

In reply to a letter from Dr. Carl G. Madsen, Jr., Painesville, it was the expression of The Council that physicians should provide review mechanisms. The concept of the usual, customary and reasonable fee calls for the judgment of a duly constituted local or state medical society committee of the physician's peers which may appropriately review and pass upon the equity and justice of his charge.

Committee Reports

Nursing Committee

Mr. Gillen presented the minutes of a meeting of the Committee on Nursing, held February 21, 1968. The report was **approved** by official action.

Joint Advisory Committee on Athletic Injuries

The minutes of the meeting of the Joint Advisory Committee on Athletic Injuries, held March 6, 1968, were presented by Mr. Gillen. Approval of the report included acceptance of the recommendation of the committee that the Postgraduate Institute on Medical Aspects of Teenage Athletics be discontinued and that in lieu thereof a half-day conference on the medical aspects of sports be conducted as a part of the annual meeting of the OSMA, beginning in 1969.

Disaster Medical Care

Mr. Campbell presented the minutes of a meeting of the Committee on Disaster Medical Care, held March 10, 1968. The acceptance of the minutes included the approval of the suggestion that Council communicate with county medical society presidents, requesting them to organize meetings in their counties to direct immediate attention to community disaster preparedness.

School Health

Mr. Gillen presented the minutes of a meeting of the Committee on School Health, held March 13, 1968. Acceptance of the report carried with it the approval of a suggestion of the committee that a half-day conference on school health be held each year in conjunction with the OSMA annual meeting.

Cancer Coordinating Committee

Mr. Gillen presented the minutes of a meeting of the Ohio Cancer Coordinating Committee, Inc., held March 28, 1968.

Dr. William A. Newton, Columbus, a member of the OSMA Committee on Cancer, addressed The Council concerning the suggestion of the Cancer Coordinating Committee that the OSMA request the American College of Surgeons to make reaccreditation of a hospital contingent upon having a cancer program which has the approval of the American College of Surgeons.

By official action, The Council agreed to continue to encourage the development of cancer registries in

general hospitals, but did not accept the recommendation that the OSMA ask the American College of Surgeons to request the Joint Commission on Accreditation of Hospitals to make reaccreditation of a hospital contingent upon having an ACS approved cancer program. The remainder of the report was accepted.

Committee on Government Medical Care Programs

Mr. Edgar reported on a meeting of the Committee on Government Medical Care Programs, held February 14, 1968. Approval of the minutes included the adoption of the following recommendations of the committee:

1. That the Ohio fiscal intermediaries for Part A, Title XVIII, be asked to make available through the councils of component societies the facts and figures of hospital audits by Social Security in the county society's jurisdiction.

2. That a protest be made to the carrier, the Social Security Administration, and to the Congress of the attempts to establish a "carve out" that denies reimbursement to the patient of that portion of the physician's eye examination fee involving procedures to determine the refractive state of the eyes.

It was agreed that The Council of the OSMA and the Committee on Eye Care work with the Ohio Ophthalmological Society and the American Association of Ophthalmology to develop a means for the carrier to reimburse the patient in a manner acceptable to the profession while still assuring the quality of ophthalmological care.

3. That the Secretary of HEW be made aware of conditions of physician participation required by the OSMA Council to be included in any such experimental plan as outlined by Public Law 90-248, Section 402, dealing with incentive plans to reduce the cost of medical care without affecting quality.

4. That the question of payment of interns, residents, and full-time hospital staff personnel who receive salaries be referred to the OSMA Committee on Hospital Relations for consideration and that this committee consult with Dr. W. T. Washam, Executive Secretary of the Ohio State Medical Board, as to the question of the legality of such payments under the Ohio Medical Practice Act.

5. That the OSMA establish and emphasize a strong policy whereby the individual physician, regardless of his type or system of practice, bill the patient under his own name for professional services, and that payment be made directly to the physician of record rather than to a computer number which covers more than one physician.

6. That a medical audit of all public health department clinics treating Title XIX patients in Ohio be made to assure quality of medical care to prevent unnecessary services and unnecessary utilization.

7. That the OSMA Council protest forcefully and effectively the double standards of the Ohio Department of Public Welfare whereby the department makes full payment for services of hospital-based physicians if services are billed by the hospital, but will not make full payment of services by physicians.

The report as a whole was accepted, except for a voluntary formulary plan, which was disapproved.

Ohio Academy of General Practice

The Council received a letter from Dr. B. Leslie Huffman, Jr., President of the Ohio Academy of General Practice, regarding a family practice seminar to be held April 24-25, 1968. The Council reaffirmed its previous position on this matter as established February 17-18, 1968.

Health Facility Planning

Dr. James C. McLarnan, Mt. Vernon, was appointed as OSMA representative to the Coordinating Committee for Health Facility Planning to replace Dr. J. G. Busby, Columbus. Dr. Busby's resignation was accepted with regret.

A set of guidelines for physician participation in areawide health planning programs was approved by The Council, such guidelines having been developed by the Ohio Coordinating Committee for Health Facility Planning.

Interest Charges on Professional Fees

A letter from Dr. Charles W. Pavey, Columbus, regarding the position of the Judicial Council of the American Medical Associaton on interest charges on professional fees, was referred to the Judicial and Professional Relations Committee for study.

Doctor Draft

Mr. Edgar announced that the doctor draft quota for July is 86 medical doctors and nine doctors of osteopathic medicine and surgery. The Council voted to support the position of Dr. Drew Davies, chairman of the Military Advisory Committee, that most of this quota must be filled by hospital residents.

Reports on Meetings

Mr. Gillen reported that the OSMA sponsored student lectures at the Ohio State University College of Medicine were attended by 104 students and their guests.

Mr. Edgar reported that 160 had attended the County Society Officers Conference on February 25 and that 32 county societies were not represented.

Dr. Light and Mr. Page reported on the Professional Relations Conference, sponsored by the National Association of Blue Shield Plans and held in Chicago, March 21-22.

The Council voted to sponsor a statewide conference on drug abuse and authorized funds to pay for the program and speaker expense.

Veterans Administration Hospital Procedures

A communication from the Trumbull County Medical Society, requesting an investigation of VA

hospital procedures affecting bed utilization and management, was referred to the Committee on Government Medical Care Programs for research and a reply.

U. S. National Health Survey

A communication from the Department of Health, Education, and Welfare, regarding the U. S. National Health Survey which is in its fourth stage in Cuyahoga and Lake Counties during May and June, 1968, was accepted for information.

Helicopter Evacuation of Patients

Correspondence with Dr. Samuel A. Marable, associate professor of surgery, Ohio State University College of Medicine, with regard to the helicopter evacuation of patients, was referred to the Committee on Environmental Health for consideration.

Private Home Care Insurance

A proposal for a pilot study of private home care insurance for people under age 65, by the Health Insurance Council, was referred to the Committee on Insurance for study.

Comprehensive Mental Health Planning

In response to a request from the Ohio Hospital Association, dated March 28, for a representative to serve as a member of a planning committee for an institute program concerning the general hospital's role in comprehensive mental health care, the President appointed Dr. Wendell A. Butcher, Columbus, as the OSMA representative.

Dr. Meredith Thanked

By official action, The Council expressed its thanks and appreciation to Dr. Lawrence C. Meredith, Elyria, for his eight years of service on The Council of the Ohio State Medical Association.

Dr. Howard Commended

The Council, by official action, expressed thanks and commendation to President Howard for the vigorous, effective, and untiring leadership characterizing his term of office.

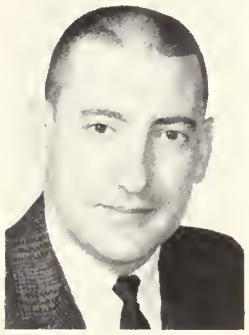
There being no further business, The Council adjourned.

Attest: HART F. PAGE
Executive Secretary

Children's Hospital, of Denver, Colorado, will hold its Summer Clinics at Vail, June 26-28. Details may be obtained from the Department of Continuing Education, Children's Hospital, Nineteenth Avenue at Downing, Denver, Colorado 80218.

New Member Appointed to Staff At OSMA Headquarters

The appointment of Robert D. Clinger to the Executive Staff of the Ohio State Medical Association was announced recently by Dr. Robert E. Howard, OSMA President. The appointment as Administrative Assistant was made after conferences between the new staff member, the Executive Staff, and the Association officers.


Robert D. Clinger

Mr. Clinger came to the OSMA staff from a position as editor of the *Gasco News,* quarterly magazine published for employees of Columbia Gas of Ohio, Inc., the Ohio Fuel Gas Company, and the Ohio Valley Gas Company in 61 Ohio counties. The three firms with headquarters in Columbus are part of the Columbia Gas System. He is a graduate of Ohio University, Athens, where he received a Bachelor of Science degree in Journalism in 1956.

In 1964, the *Gasco News,* under Clinger's editorship, received first prize in the picture story competition among publications from throughout Ohio in the annual All-Ohio Industrial Editors "This Is My Best" contest. The publication also has been cited for placing in the top 20 per cent among magazines in its class in the annual International Council of Industrial Editors competition.

A native Ohioan, Clinger was born in Findlay and graduated from Findlay Senior High School. While pursuing his education he worked in various editorial capacities for the *Republican-Courier,* daily newspaper in Findlay. From 1956 to 1959, he served as navigator in the U. S. Air Force, and attained the rank of first lieutenant.

Clinger is a member of the United Presbyterian Church of Worthington and the Central Ohio Chapter of Sigma Delta Chi, professional journalism society. He is a past president and member of the Central Ohio Business and Industrial Editors Association. In both 1961 and 1966, he served as general chairman for the All-Ohio Conference of Industrial Editors in Columbus. The family residence is at 240 Larrimer Avenue, Worthington. He and his wife, Elizabeth, have three children — David, age 6, Scott, 4, and Melanie, 20 months.

As Administrative Assistant in the OSMA headquarters office, he will engage in liaison work with various organizations and individuals, serve as secretary to several of the Association's Committees, arrange meetings authorized by OSMA Officers, participate in the Association's legislative activities, engage in the Association's various publications activities, and perform other staff duties as they arise.

ACCREDITATION NOTES . . .



A Question-and-Answer Column Conducted in Collaboration with

The Joint Commission on Accreditation of Hospitals

John D. Porterfield III, M. D., Director

Q. Please list the important factors the JCAH considers before accrediting — or refusing to accredit — a hospital.

A. The full answer to this question would be fairly long and is contained in the Basic Publications of the JCAH (now actively under revision for a new edition). Briefly, however, the JCAH is concerned about the safety, sanitation, and utility of the physical plant; the organization, activity, interrelation, and records of the governing body, administration, and medical staff; the provision of adequate facilities, procedures, and qualified personnel for the services offered; the provision and adequacy of dietary, nursing, pharmacy, clinical laboratory, and radiologic services; the completeness and pertinence of patients' clinical records. From all these factors, the JCAH surveyor is most interested in the quality of care of the patients and the evidence of the continuing efforts of the organized medical staff to study the clinical practices carried on and to make provision for continuing education of its members from this study.

Q. To what degree is a paid director of medical education of value in a private hospital as regards securing intern and resident physicians who are graduates of American schools?

A. It would seem logical to expect that a full-time director of medical education would be an asset in securing qualified house staff in these days of many more positions than medical school graduates. An assessment of the nature and degree of his value would more properly and accurately come from the Council on Medical Education of the AMA.

Q. Do members of the JCAH actually inspect hospitals, and, if so, how often?

A. All hospitals seeking accreditation are surveyed by personal visit before accreditation decision is made. All accredited hospitals are resurveyed by personal visit at least every three years. Accreditation surveys (just over 2,000 done in 1967) are done by physician-surveyors of the JCAH. These physician-surveyors are selected from applicants who have had experience in the clinical practice of medicine and some past record of experience with organized hospital medical staffs (e. g., have been chief of staff, chairman of a major staff committee or the like). They are given an intensive orientation course in survey and evaluation techniques and in the interpretation of JCAH standards, and serve a brief "apprenticeship" under an experienced surveyor before beginning their own survey schedules. Each year the physician-surveyors go through an intensive workshop to maintain their interest, ability, and knowledge of new policies.

Commissioners of the Board often accompany physician-surveyors on hospital surveys and occasionally conduct an accreditation survey personally. The Board regularly reminds itself that the review of a survey and the vote on accreditation is best done after direct personal experience with the survey procedures.

Q. What is the place of full-time paid directors of major services in private hospitals?

A. This is not a requirement of JCAH. However, there seems to be a trend in the United States toward an increase in the number of full-time directors of the major clinical services. His function is much like that of a non-full-time department or service head or chief except that he devotes more concentrated effort to the tasks. Briefly, he is responsible to the chief of staff for the functioning of his department or service and shall give general supervision to all the clinical work done within his department, both indigent and private. He is usually expected to see to the professional administrative work of his department and to insure a continuing review of the clinical work by the members of that department.

Q. Should private (nonuniversity affiliated) hospitals maintain internships and residencies with foreign school graduates or should these students more properly belong in university centers?

A. This calls for a value judgment outside the jurisdiction of JCAH and would come better from the Council on Medical Education of the American Medical Association. Query Dr. William Ruhe, Secretary of the Council, at 535 North Dearborn Street, Chicago, Illinois 60610.

Implied Consent Law . . .

Physicians Warned of Possible Consequences Of Withdrawing Blood for Drunk Driving Test

BEFORE WITHDRAWING BLOOD for purposes of the alcohol test provided under the new "implied consent law," the physician must be satisfied that the person has given his consent and that such consent is with complete information and understanding of the consequences, OSMA legal counsel advises the profession.

Physicians cannot be ordered to withdraw blood of a person accused of driving while under the influence of alcohol, OSMA attorneys state. "The profession of a physician is the treatment of patients requiring aid, not crime investigation."

It is important for the physician to remember that the Ohio statute affords no immunity from civil liability for the withdrawal of blood. OSMA staff and legal counsel attempted to insert immunity provisions in the regulations as they were adopted. The Ohio Department of Health refused.

Therefore, until proper amendments are adopted by the Ohio legislature, hopefully in early 1969, physicians for their own protection are advised to follow the advice contained in the following article.

* * *

Text of Counsels' Statement

On January 1, 1968, there became effective, in the State of Ohio, a statute commonly known as the "Implied Consent Law." This statute, and others like it, are a result of the growing concern over the menace to safety that is represented by persons driving while under the influence of alcohol. What the statute says, in effect, is that anyone operating a motor vehicle on a public highway in the State of Ohio impliedly consents to submit to a chemical test to determine the alcoholic content of his blood.

The State of New York, in 1953, enacted the first implied consent statute. Between the year 1953 and the present, the courts of New York, and of other states with similar statutes, have tested the constitutionality of these laws on virtually every available ground. Consequently, the statute, as enacted in Ohio, represents legislation which is almost free from constitutional attack. To say almost free from constitutional attack, of course, baits the reader into the supposition that the statute is not entirely foolproof. As case law now stands, the statute is not subject to a constitutional onslaught. However, the inherent instability of constitutional law will not permit a statement that any statute, of this type, is always or forever free from assault.

Constitutionality of the Law

Of particular interest are United States Supreme Court findings concerning blood tests, and their application in Ohio. In *Breithaupt v. Abram,* 352 U. S. 432 (1956), the Supreme Court said that the taking of a blood test by a skilled physician does not "shock the conscience of the court," nor does it offend the court's "sense of justice" and, therefore, is not an illegal search and seizure. It is to be noted however, that Justices Warren, Black, and Douglas dissented from this finding. The latest significant Supreme Court case concerning blood tests is *Schmerber v. California,* 384 U. S. 757 (1966). In that case, the opinion of the court was that blood tests, taken to determine the intoxication of a driver, are not violations of the Fifth Amendment since they do not compel the accused to give evidence of a testimonial or communicative nature. The problem with the strength of the *Schmerber* case is that four of the nine Justices dissented from the opinion.* Consequently, the law as to the constitutionality of required blood tests could easily change if (1) a case were to arise with a factual situation that would swing another Justice to the dissent, or (2) a new "liberal" Justice should gain the bench as a replacement for a "conservative."

There is another constitutional problem, but it relates mainly to defending one accused under the statute, not to the constitutionality of the statute itself. The statute requires that before any of its provisions begin to take effect, an arrest must be made. In this respect, the Miami County Court of Appeals in the case of *Piqua v. Hinger,* 13 Ohio App. 2d 108 (1967), said in syllabus 2:

> "The principles enunciated in Miranda v. Arizona, 384 U. S. 436, delineating procedures to safeguard the Fifth Amendment privilege against self-incrimination during in-custody interrogation are applicable where the accused is charged with the offense of operating a motor vehicle while under the influence of intoxicating liquor."

*Justices Warren, Black, Douglas, and Fortas dissented, while Justice Harlan concurred with Justice Stewart who said that the case in no way involved the Fifth Amendment.

The *Miranda* case noted that as soon as the accused is arrested he must be advised of his rights, not the least of which are the rights to remain silent and to an attorney. This is of considerable interest since the two hours after the violation, within which the test must be given, might easily pass before an attorney can be summoned for the accused.

The Statute Itself

The statute, as it now exists (see text at end of this article), primarily says that a court will admit evidence of the alcoholic content of an arrested person's blood if there was a chemical analysis of his blood, urine, breath or other bodily substance withdrawn within two hours of the alleged violation; only a physician or registered nurse can withdraw blood for the blood test; presumptions as to intoxication arise from certain concentrations of alcohol; the accused may have his own test administered in addition to the one directed under the statute; the type of test given is designated by the law enforcement agency which employs the arresting officer; being dead, unconscious, or in any condition which renders the accused incapable of refusing to take the test, does not withdraw the consent implied under the statute; the person arrested must be advised, at a police station, of the consequences of his refusal to submit to the designated test. The statute also includes the consequences for refusing to submit to the designated test, and the method by which an appeal is taken from the instigation of said consequences.

What Is the Statute Lacking?

Research into the statutes existing in other states leads the seeker to the conclusion that the Ohio legislators did little to investigate possible implementation of the Uniform Implied Consent law. Since 1953, the date of the initiation of the New York statute, a great majority of the states have adopted some form of an implied consent law. Although the Uniform Implied Consent act may cover the constitutional problems, a quick reference to the statutes of other states should have led Ohio legislators to make additions to the standard. These additions would provide improvements going, not to the validity of the statute, but rather to the ease of its operation.

At least eight states* include, in their implied consent law, an exemption from civil liability for a physician, nurse, or other designated person administering a blood test. There are, in fact, other Ohio statutes† which provide exemptions from liability for medical personnel in the practice of their profession. California, Michigan, Connecticut, and Rhode Island provide, in their statutes, that a person who is afflicted with hemophilia, or any other condition requiring the use of an anticoagulant under the direction of a physician or surgeon, need not submit to a blood test. Ten other states‡ have provisions which allow the withdrawal of blood by personnel other than a doctor or registered nurse. Seven states§ give the accused person a choice of which test he will be given. North Dakota provides that if an accused is unconscious or otherwise incapable of refusal, consent is withdrawn and the test may not be given; this however, does not apply to a dead person.

Amendments Necessary

What then should be added to improve the Ohio statute?

1. Change the provisions which allow blood to be withdrawn only by "a physician or registered nurse," to include withdrawal by a medical technician under the direction of a physician.

2. Include a provision reading as follows:

"No physician, registered nurse, or medical technician shall incur any civil or criminal liability as the result of the proper administering of a blood test, when directed or requested to administer such test by a peace officer or by the person submitting to the test."

3. Insert a provision that reads:

"No blood sample shall be taken from any person who is afflicted with hemophilia, nor from any person who is afflicted with a condition requiring the use of, and who is in fact using, an anticoagulant under the direction of a physician."

4. Change Section 4511.191 (C) to read:

"Any person who is dead shall be deemed not to have withdrawn consent provided by Division (A) of this section and the test may be administered subject to sections 313.11 to 313.16, inclusive, of the Revised Code. Any person who is unconscious or who is otherwise in a condition rendering him incapable of refusal shall be deemed to have withdrawn consent to a blood test provided by Division (A) of this section and the test may not be administered."

5. Delete the words "other bodily substance" from the second paragraph of Section 4511.19. There is no necessity to include these words when no other tests are provided for, other than ones testing the breath, blood, or urine.

The Doctor's Position

The following questions should be resolved by any physician who is confronted, under the present statute, with the problem of withdrawing blood from an accused in order that it might be tested to determine its alcoholic content.

1. Is there a possibility of civil liability? Without the liability exemption, as provided for by other states and proposed above, the physcician, registered

*New York; California; Florida; Michigan; North Dakota; Nebraska; Utah; Virginia

†Ohio Revised Code §§ 2151.421; 2305.23; and 2917.44.

‡California; Florida; New York; Oklahoma; Utah; Connecticut; Iowa; Kansas; North Dakota; Nebraska

§California; Michigan; Oklahoma; Nebraska; Vermont; Connecticut; Iowa

nurse, or other person withdrawing a blood sample is not immune from civil liability for his or her actions.

2. What should be the position, in the following situations, of medical personnel requested or directed to withdraw blood for the purpose of alcohol testing:

a) If the accused is dead?
The blood may be withdrawn.

b) If the accused is unconscious, too intoxicated, or otherwise incapable of giving consent?
Do not withdraw the blood solely for the purpose of testing the alcoholic content for crime investigation. If the withdrawal and/or testing is indicated for diagnosis or treatment, the use for investigation is properly collateral.

c) If the accused has given consent?
Withdraw the blood only if the person is capable of giving an informed consent, and in your opinion, the consent given is with full knowledge and understanding of the consequences, both physical and legal, of the withdrawal and testing.

d) If the person refuses to give consent?
Do not withdraw the blood.

3. Can a physician be ordered to withdraw blood from a person accused of driving while under the influence of alcohol? The profession of a physician is the treatment of patients requiring aid, not crime investigation. A physician has no obligation to practice his profession. 42 *Ohio Jur.* 2d, Physicians and Surgeons, Section 12, reads as follows:

> "The existence of a license law and the possession of a license do not enlarge a physician's duty in regards to accepting an offered patient. Physicians are not public servants who are bound to serve all who seek them, as are innkeepers, common carriers, and the like. So far as the law is concerned, a physician has a right to select his patients and he is under no obligation to undertake the treatment of every patient who applies to him."

4. Who pays the cost incurred in administering any test? In an Ohio Attorney General's Opinion, No. 68-037, appears the following language in response to an identical question:

> "3. The law enforcement agency designing which test or tests are to be administered is responsible for the expense of such test or tests."

Should the accused request an additional test, he is contracting for the service of the physician and, in that respect, is bound himself to pay for such service.

Conclusion

It is important for the physician, or nurse, to remember that the statute affords no immunity from liability for the withdrawal of blood. Consequently, before withdrawing blood, for purposes of the alcohol test, the physician or nurse should be satisfied that the person, from whom the blood is taken, has given his consent and that consent is with complete information and understanding of the consequences.

Text of Pertinent Provisions of the Law

Sec. 4511.19. No person who is under the influence of alcohol, narcotic drugs, or opiates shall operate any vehicle, streetcar, or trackless trolley within this state.

In any criminal prosecution for a violation of this section, or ordinance of any municipality relating to driving a vehicle while under the influence of alcohol, the court may admit evidence on the concentration of alcohol in the defendant's blood at the time of the alleged violation as shown by chemical analysis of the defendant's blood, urine, breath, or other bodily substance withdrawn within two hours of the time of such alleged violation. When a person submits to a blood test at the request of a police officer under section 4511.191 of the Revised Code, only a physician or a registered nurse shall withdraw blood for the purpose of determining the alcoholic content therein. This limitation does not apply to the taking of breath or urine specimens. Such bodily substance shall be analyzed in accordance with methods approved by the director of health by an individual possessing a valid permit issued by the director of health pursuant to section 3701.143 of the Revised Code. Such evidence gives rise to the following:

(A) If there was at that time a concentration of less than fifteen hundredths of one per cent by weight of alcohol in the defendant's blood, such fact shall not give rise to any presumption that the defendant was or was not under the influence of alcohol, but such fact may be considered with other competent evidence in determining the guilt or innocence of the defendant.

(B) If there was at that time a concentration of fifteen hundredths of one per cent or more by weight of alcohol in the defendant's blood, it shall be presumed that the defendant was under the influence of alcohol.

Upon the request of the person who was tested, the results of such test shall be made available to him, his attorney, or agent, immediatley upon the completion of the test analysis.

The person tested may have a physician, or a qualified technician, chemist, registered nurse, or other qualified person of his own choosing administer a chemical test or tests in addition to any administered at the direction of a police officer, and shall be so advised. The failure or inability to obtain an additional test by a person shall not preclude the admission of evidence relating to the test or tests taken at the direction of a police officer.

Sec. 4511.191. (A) Any person who operates a motor vehicle upon the public highways of this state shall be deemed to have given consent to a chemical test or tests of his blood, breath, or urine for the purpose of determining the alcoholic content of his blood if arrested for the offense of driving while under the influence of alcohol. The test or tests shall be administered at the direction of a police officer having reasonable grounds to believe the person to have been driving a motor vehicle upon the public highways of this state while under the influence of alcohol. The law enforcement agency by which such officer is employed shall designate which of the aforesaid tests shall be administered.

(B) Any person who is dead, unconscious, or who is otherwise in a condition rendering him incapable of refusal, shall be deemed not to have withdrawn consent provided by division (A) of this section and the test or tests may be administered, subject to sections 313.11 to 313.16, inclusive, of the Revised Code.

(C) Any person under arrest for the offense of driving a motor vehicle while under the influence of alcohol shall be advised at a police station of the consequences of his re-

fusal to submit to a chemical test designated by the law enforcement agency as provided in division (A) of this section. The advice shall be in a written form prescribed by the registrar of motor vehicles and shall be read to such person. The form shall contain a statement that the form was shown to the person under arrest and read to him in the presence of the arresting officer and one other police officer or civilian police employee. Such witnesses shall certify to this fact by signing the form.

(D) If a person under arrest for the offense of driving a motor vehicle while under the influence of alcohol refuses upon the request of a police officer to submit to a chemical test designated by the law enforcement agency as provided in division (A) of this section, after first having been advised of the consequences of his refusal as provided in division (B) of this section, no chemical test shall be given, but the registrar of motor vehicles, upon the receipt of a sworn report of the police officer that he had reasonable grounds to believe the arrested person had been driving a motor vehicle upon the public highways of this state while under the influence of alcohol and that the person refused to submit to the test upon the request of the police officer and upon the receipt of the form as provided in division (C) of this section certifying that the arrested person was advised of the consequences of his refusal, shall revoke his license or permit to drive, or any nonresident operating privilege for a period of six months; or if the person is a resident without a license or permit to operate a motor vehicle in this state, the registrar shall deny to the person the issuance of a license or permit for a period of six months after the date of the alleged violation, subject to review as provided in this section.

(E) Upon revoking the license or permit to drive or nonresident operating privilege of any person, or upon determining that the issuance of a license or permit shall be denied to the person, as provided in division (D) of this section, the registrar shall immediately notify the person in writing and upon his request afford him an opportunity for a hearing in the same manner and under the same conditions as is provided in section 4507.40 of the Revised Code for notification and hearings in the cases of discretionary suspension of licenses, except that the scope of such hearing for the purposes of this section shall cover the issues of whether a police officer had reasonable ground to believe the person had been driving a motor vehicle upon the public highways of this state while under the influence of alcohol, whether the person was placed under arrest, and whether he refused to submit to the test upon request of the officer, and whether he was advised of the consequences of his refusal. The registrar shall order that the revocation or determination that there should be a denial of issuance be rescinded or sustained.

(F) If the revocation or determination that there should be a denial of issuance is sustained after such hearing, the person whose license or permit to drive or nonresident operating privilege has been revoked, or to whom a license or permit is denied, under this section, may file a petition in the municipal court or the county court, or in case such person is a minor in the juvenile court, to review the final order of revocation or denial by the registrar in the same manner and under the same conditions as is provided in section 4507.26 of the Revised Code in the cases of discretionary revocations and denials.

(G) When it has been finally determined under the procedures of this section that a nonresident's privilege to operate a motor vehicle in this state has been revoked, the registrar shall give information in writing of the action taken to the motor vehicle administrator of the state of the person's residence and of any state in which he has a license.





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Although not a thiazide, HYDROMOX may possess certain characteristics of the thiazides. They have been known to cause jaundice with liver involvement and pancreatitis; hematological complications such as purpura with or without thrombocytopenia and leukopenia (neutropenia); increases of serum uric acid; decreased glucose tolerance as evidenced by hyperglycemia and glycosuria thus aggravating or provoking diabetes mellitus and azotemia in patients with renal disease; photoallergy. Discontinue use a few days prior to elective surgery. When added to a regimen that includes ganglionic-blocking agents, the dosage of these latter preparations should be reduced. Also reduce dosage when one or more of these antihypertensive agents is added to an established HYDROMOX regimen. Contraindicated in anuria. Observe for possible hematologic complications.

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The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 6, 1968.

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Who's Who . . . NATIONALLY

Listed below in alphabetical order are the photographs and curriculum vitaes on 20 out-of-state speakers which will be appearing during the 1968 OSMA Annual Meeting in Cincinnati, May 13-17. Keep a close watch for the com-



EDWARD R. ANNIS, M.D.
MIAMI, FLORIDA

Past President of the American Medical Association. Appearing on "Medicare Plus Two Years – How Is the Medical Profession Faring?" General Session.



WALTER C. STOLOV, M.D.
SEATTLE, WASHINGTON

Associate Professor, Department of Physical Medicine and Rehabilitation, University of Washington. Appearing on Physical Medicine and Rehabilitation program.





REV. DR. PAUL B. McCLEAVE
CHICAGO, ILLINOIS

Director, Department of Medicine and Religion, American Medical Association. Appearing on "The Pill" panel General Session.



JACK L. PULEC, M.D.
ROCHESTER, MINNESOTA

Practice Otologic and Neuro-otologic Surgery at the Mayo Clinic; Associate Professor of Otolaryngology and Rhinology in the Mayo Graduate School of Medicine. Appearing on the E.N.T. Program.



PAUL F. WEHRLE, M.D.
LOS ANGELES, CALIFORNIA

Chief Physician, Children's Division, Los Angeles County General Hospital. Appearing on Health Commissioners Program.



FRANK J. AYD, JR., M.D.
BALTIMORE, MARYLAND

Diplomate in Psychiatry. Internationally known lecturer, writer, and psychiatrist. He is editor and publisher of the Medical-Moral Newsletter and the International Drug Therapy Newsletter. Appearing on "The Pill" panel General Session.



MAX S. SADOVE, M.D.
CHICAGO, ILLINOIS

University of Illinois Anesthesiology, Head, Department of Research and Educational Hospitals. Appearing on Anesthesiologists and Chest Physicians Program.



HARRY SHWACHMAN, M.D.
BOSTON, MASSACHUSETTS

Clinical Professor of Pediatrics at the Children's Hospital Medical Center, Harvard Medical School. Chairman of the Education Committee of the National Cystic Fibrosis Research Foundation. Appearing on Pediatrics Program.



JOHN C. GAISFORD, M.D.
PITTSBURGH, PA.

Director of the Departments of Plastic And Reconstructive Surgery, Allegheny General Hospital and the Western Pennsylvania Hospital. Clinical Assistant Professor of Surgery, University of Pittsburgh School of Medicine. Appearing on the Plastic Surgery Section Program – General Session.



OLIVER FIELD, LLB.
CHICAGO, ILLINOIS

Department of Investigation, American Medical Association. Appearing on "Medical Hooey" General Session.



SAMUEL BELLET, M.D.
PHILADELPHIA, PA.

Director, Division of Cardiology at the Philadelphia General Hospital. Member of the President's Commission on Cancer, Heart Disease and Stroke. Appearing on Occupational Medicine Program.

KNOWN SPEAKERS

plete Official Program which will be mailed to each member of the Ohio State Medical Association around April 15. Be certain to check your program for the exact time and place of each presentation you plan to attend.



DR. ALAN J. MODNEY
DUBLIN, IRELAND

Senior Ophthalmic Surgeon to the Royal Victoris Eye and Ear Hospital, Dublin. Honorary member of the Society of British Neurological Surgeons Appearing on Ophthalmology program.

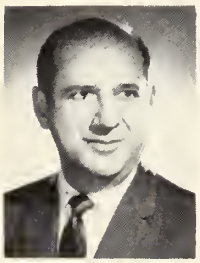


LAURENCE P. SKENDZEL, M.D.
TRAVERSE CITY, MICHIGAN

Pathologist at Munson Medical Center; Secretary of the Standards Committee of the College of American Pathologists. Appearing on the Conference on Laboratory Medicine.

EDWARD T. TYLER, M.D.
LOS ANGELES, CALIF.

Clinical Professor of Medicine and Obstetrics and Gynecology, UCLA School of Medicine; Medical Director, Family Planning Centers of Greater Los Angeles. Appearing on "The Pill" panel General Session.



FRANK VELLIOS, M.D.
INDIANAPOLIS, INDIANA

Professor and Chairman of Pathology, Indiana University School of Medicine. Appearing on Pathology program.



E. CUYLER HAMMOND, SC.D.
NEW YORK, N.Y.

Vice President for Epidemiology and Statistics, American Cancer Society. Appearing on "Tenth Annual Cancer Conference" General Session.



JOHN W. GREENE, JR., M.D.
LEXINGTON, KENTUCKY

Chairman, Department of Obstetrics and Gynecology, University of Kentucky Appearing on Obstetrics and Gynecology program.



GEORGE J. GARCEAU, M.D.
INDIANAPOLIS, INDIANA

Distinguished Professor Emeritus of Orthopaedic Surgery, Indiana University School of Medicine; Past President of the American Board of Orthopaedic Surgery. Appearing on Orthopaedic program.

20 OUT-OF-STATE SPEAKERS WHICH WILL BE APPEARING DURING THE 1968 OSMA ANNUAL MEETING



WILLIAM H. GORDON, M.D.
LUBBOCK, TEXAS

Fellow of Cardiovascular Diseases, Massachusetts General Hospital (Harvard); Certified American Board of Internal Medicine. Appearing on "Medical Hooey" General Session.



JAMES B. GILLESPIE, M.D.
EVANSTON, ILLINOIS

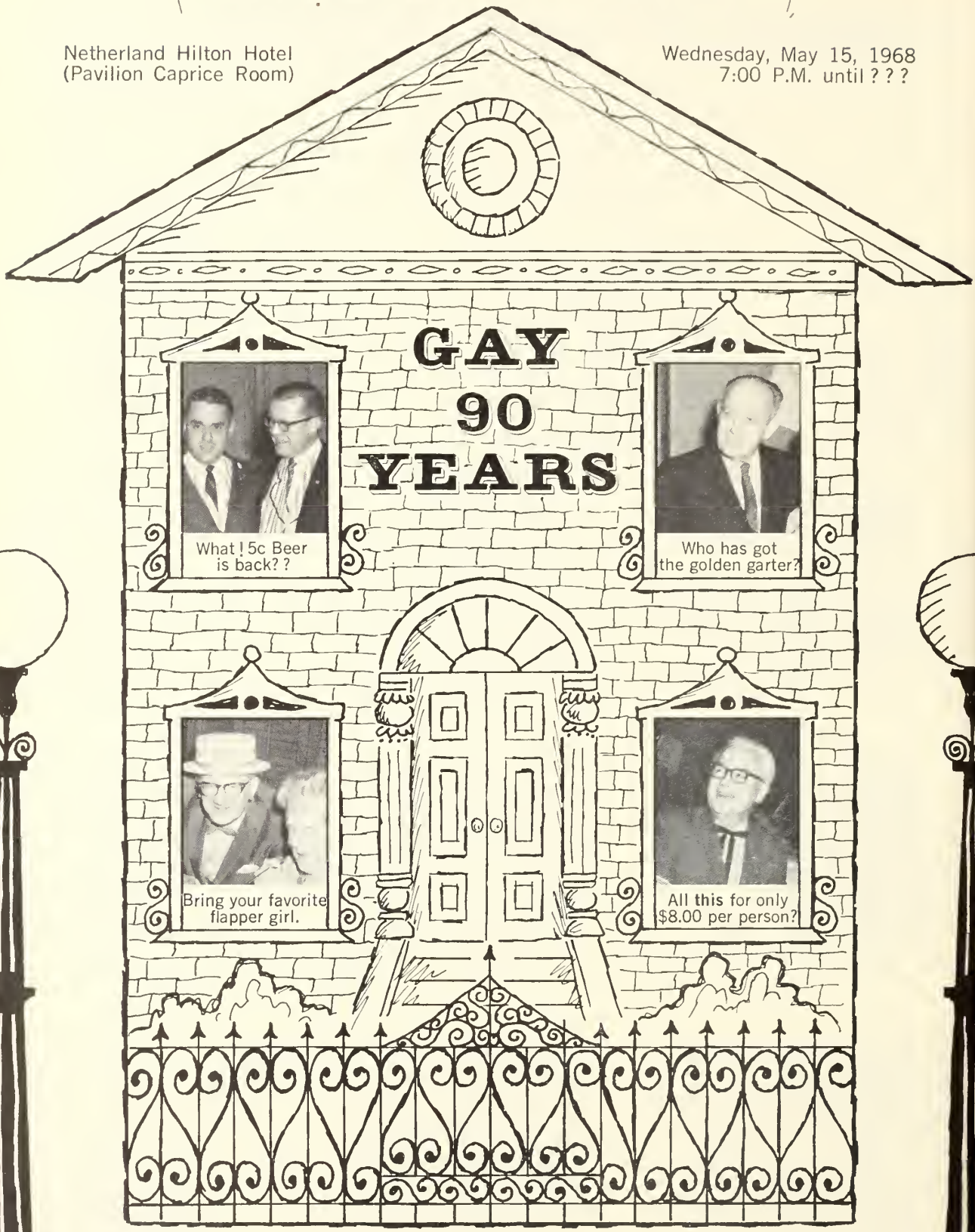
Secretary for Chapters, American Academy of Pediatrics. Appearing on Pediatrics program.



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7:00 P.M. until ? ? ?



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THURSDAY, MAY 16
Room 210
Cincinnati-Exposition Center


Congressman Taft

Speaker.... The Honorable
ROBERT TAFT, JR.
FIRST OHIO DISTRICT

11:30 A. M.	Cash Bar
12:00 Noon	Luncheon
12:45 P. M.	"Lets Take a Look at the Record!"
	Progress Report — Frank H. Mayfield, M. D., Chairman, OMPAC Board
1:00 P. M.	After Luncheon Speaker — Hon. Robert Taft, Jr.

Tickets . . . $5.00 per person



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Thursday, May 16
Cincinnati-Exposition Center
11:30 A.M.
Featuring Congressman
ROBERT TAFT, JR.

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OHIO STATE MEDICAL ASSOCIATION
ANNUAL MEETING

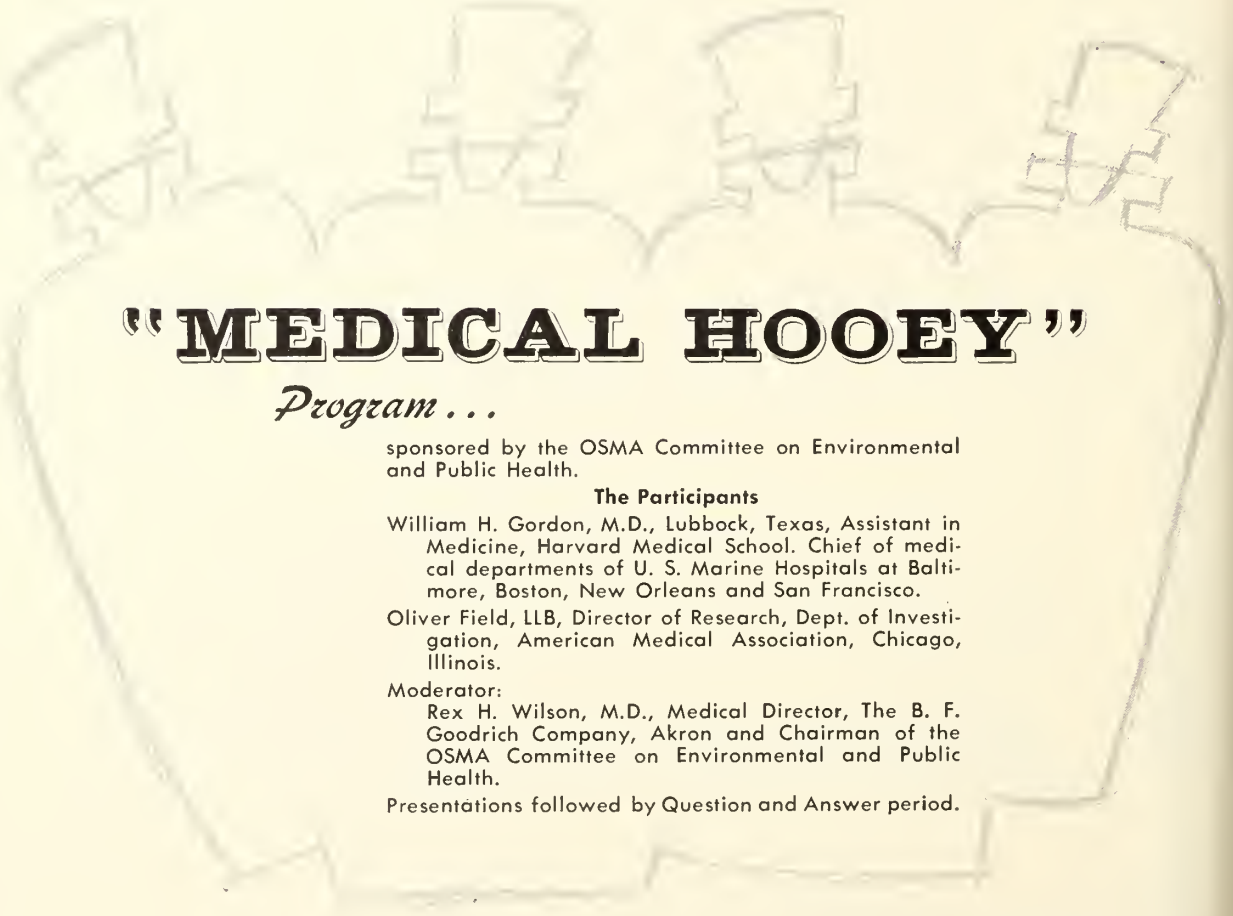
GENERAL SESSION

TUESDAY, MAY 14

1:00 P.M.

ROOM NO. 209

Cincinnati-Exposition Center



"MEDICAL HOOEY"

Program . . .

sponsored by the OSMA Committee on Environmental and Public Health.

The Participants

William H. Gordon, M.D., Lubbock, Texas, Assistant in Medicine, Harvard Medical School. Chief of medical departments of U. S. Marine Hospitals at Baltimore, Boston, New Orleans and San Francisco.

Oliver Field, LLB, Director of Research, Dept. of Investigation, American Medical Association, Chicago, Illinois.

Moderator:
Rex H. Wilson, M.D., Medical Director, The B. F. Goodrich Company, Akron and Chairman of the OSMA Committee on Environmental and Public Health.

Presentations followed by Question and Answer period.

GENERAL SESSION
FRIDAY, MAY 17, 1968
9:00 A.M.



ROOM NO. 209
Cincinnati
Exposition
Center

Featuring . . .

Frank J. Ayd, Jr., M.D., Baltimore, Maryland

Helen I. Glueck, M.D., Cincinnati General Hospital

Rabbi Rabert L. Katz, Cincinnati, Professor af Human Relatians, Hebrew University College

Rev. L. H. Mayfield, Chaploin, Christ Hospitol, Cincinnati

The Rev. Father Danald McCarthy, Cincinnati, Assaciate Professor of Philosophy, Mt. St. Marys Seminary

Rev. Dr. Paul B. McCleave, Director, Dept. af Medicine and Religion, American Medical Association, Chicaga, Illinais

Edward T. Tyler, M.D., Los Angeles, Califarnia, Clinical Professar of Medicine, Obstetrics ond Gynecalagy, UCLA School af Medicine

Panel Program spansared by the OSMA Committee an Medicine and Religion.

"You CAN Teach an Old Dog New Tricks"

CONFERENCE ON LABORATORY MEDICINE

FRIDAY, MAY 17

9:00 A.M.

Room 211, Cincinnati-Exposition Center

Program sponsored by the OSMA Committee on Laboratory Medicine.

The Participants

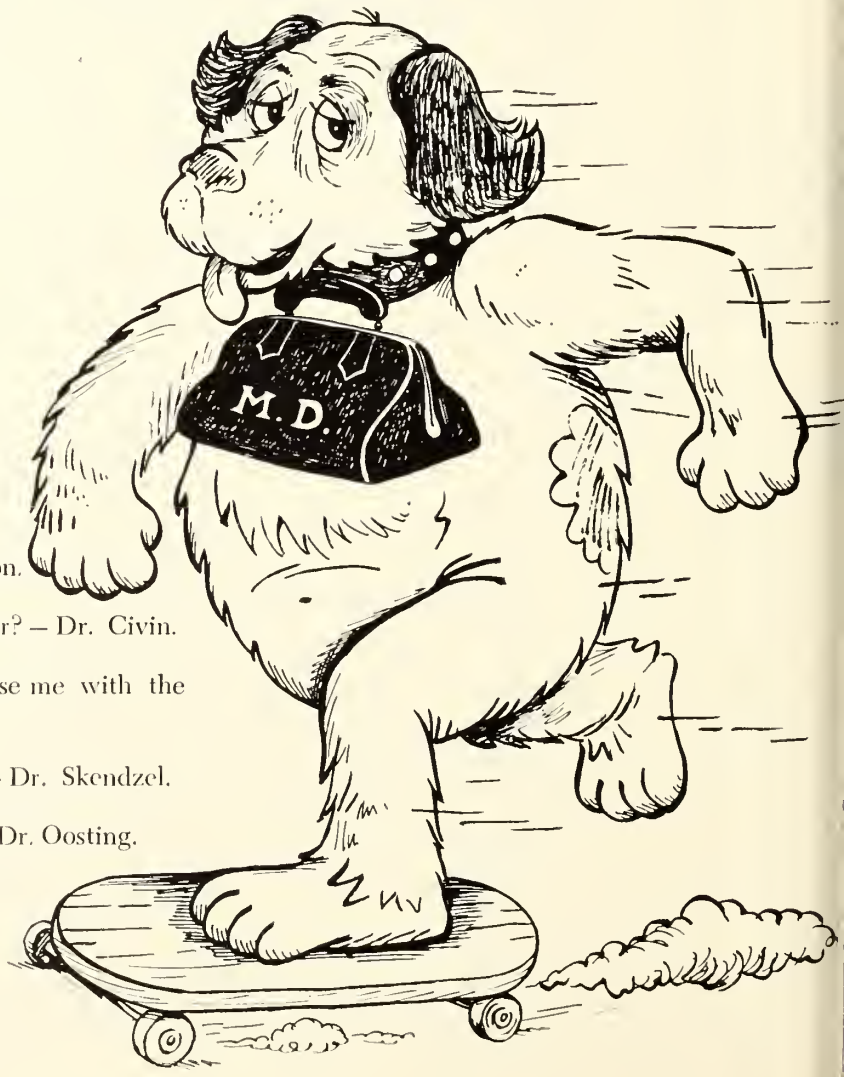
Hal Civin (W. Harold), M.D., Cincinnati, University of Cincinnati College of Medicine, Professor and Chairman, Dept. of Laboratory Medicine, Cincinnati General Hospital.

Daniel J. Hanson, M.D., Toledo, Member, OSMA Committee on Laboratory Medicine.

George C. Hoffman, M.D., Cleveland, Dept. of Clinical Pathology, Cleveland Clinic.

Melvin Oosting, M.D., Dayton, Dir., Diagnostic Laboratories, Miami Valley Hospital, Chairman, Committee on Laboratory Medicine.

Laurence P. Skendzel, M.D., Traverse City, Michigan, Pathologist at Munson Medical Center; Secretary of the Standards Committee of the College of American Pathologists.



Panel Program

Moderator: Dr. Oosting

9:00 Control Out of Chaos —Dr. Hanson.

9:15 What Do You Want That Test For? — Dr. Civin.

9:30 I've Got a Number — Don't Confuse me with the Facts — Dr. Hoffman.

9:45 Quality Control — Who Needs It! — Dr. Skendzel.

10:00 Where Do We Go From Here? — Dr. Oosting.

digestive disorders

B and C vitamins aid therapy: Nausea, vomiting, and severe diarrhea may seriously interfere with the digestion and absorption of nutrients. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, may help meet the needs of these patients. In digestive disorders, as in many stress conditions, STRESSCAPS vitamins aid therapy.

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Vitamin B_1 (as Thiamine Mononitrate)	10 mg
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Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

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Medical Society Officers' Conference . . .

Key Persons from Ohio County Medical Societies Meet With Ohio State Association Officers for Discussion of Vital Topics

THE ANNUAL CONFERENCE of County Medical Society Officers was held in Columbus at the Pick-Fort Hayes Hotel, on February 25, under sponsorship of the Ohio State Medical Association. Attendance was 160, with 56 County Medical Societies and all 11 Councilor Districts represented.

Dr. Robert E. Howard, Cincinnati, President of the Ohio State Medical Association, presided at the morning session, and welcomed those present to the get-together. Dr. Howard emphasized the "grass-roots" character of the conference and reminded those present that through such conferences the voices of physicians in the local areas are being heard at the "floor" level of the American Medical Association.



Dr. Howard

Dr. Howard, who has been an outspoken proponent for maintenance of the patient-physician relationship in all phases of practice, urged physicians to back their local, state, and national organizations, even though they may not agree with all organization actions.

David B. Weihaupt, Chicago, is Field Representative for the American Medical Association in the region including Ohio. Under the provocative title, "What Has the AMA Ever Done for You?" he related literally hundreds of facets of the AMA's extensive program for the benefit of medicine and the public health. See excerpts of his talk on page 624 of this issue.



Mr. Weihaupt

Sewell Milliken, chief of the Office of Comprehensive Health Planning in the headquarters of the



Mr. Milliken

Ohio Department of Health, discussed "Comprehensive Health Planning in Ohio" under Public Law 89-749.

This Federal program amends provisions of the Public Health Service Act relating to grants to states. The Ohio Department has been designated the agency in Ohio under which the program is administered.

Mr. Milliken pointed out that area health planning is not new in Ohio and goes back more than 20 years. More than one Ohio county received national recognition for pioneering work in this field. He stated that 70 per cent of funds under this program are expended at the local level and that emphasis in the program is toward local planning.



Dr. Washam

Dr. W. Thomas Washam, Executive Secretary of the State Medical Board of Ohio, discussed the Ohio Medical Practice Act as revised recently by the Ohio General Assembly. Dr. Washam is both a physician and an attorney, and in addition to his part-time activities with the Medical Board, practices in the medico-legal field. The text of his talk was printed in the April issue of *The Journal,* beginning on page 502.



Dr. Petznick

Dr. George W. Petznick, Cleveland, discussed "Medical Ethics and Reasonable Fees." He is a Delegate of the OSMA to the American Medical Association and a member of the AMA Judicial Council. His talk dealt with the application of the *Principles of Medical Ethics* to problems involving usual, customary, and reasonable fees. For the text of his talk, please refer to March issue of *The Journal,* page 363.



Dr. Budd

Dr. John H. Budd, Cleveland, chairman of the Ohio Delegation to the AMA, presented a report in behalf of the Delegation. Dr. Budd discussed a number of measures anticipated for discussion and possible action at the AMA Annual Convention in San Francisco in June. He also discussed matters pending action of the OSMA House of Delegates at the Cincinnati Annual Convention in May, and of interest on the national level.

(Contd. on Next Page)

Officers Conference—(Contd.)

Luncheon was served in the Regency Ballroom of the hotel, compliments of the Ohio State Medical Association.



Dr. Light

Dr. Theodore L. Light, Dayton, President-Elect of OSMA, presided at the afternoon session. He discussed some of the pressing matters that are facing the profession and touched briefly on points that will receive particular attention during his year in office as President, beginning in May. Dr. Light is also a Delegate to the AMA.



Dr. Porterfield

Dr. H. William Porterfield, Columbus, chairman of the OSMA Committee on Government Medical Care Programs, discussed some of the policies established by the State Association in regard to medical and health programs under various governmental agencies. The extent of these programs is emphasized by the fact that a 28-page supplement on this subject was published in two installments in the May and June, 1967, issues of *The Journal*. The text for this supplement was prepared under direction of the committee headed by Dr. Porterfield.

Important features of the meeting were 11 individual Councilor District conferences at which matters of general and particular local interest were discussed. During this same period, AMA Delegates and Alternates met for discussion of matters of particular interest to the delegation.

The 1968 Conference was concluded with a general session during which Dr. Howard discussed some general policy matters and reviewed highlight features of the coming OSMA Annual Meeting in Cincinnati, May 13-17.

Deadline Set on Abstracts of Papers for Heart Program

June 7 has been set as the deadline for abstracts of papers to be presented at the American Heart Association 1968 Scientific Sessions.

The sessions, extended this year to four days, from Thursday, November 21, through Sunday, November 24, will be held in the Americana Hotel, Bal Harbour, Florida.

Papers should be based on original investigations in, or related to, the cardiovascular field. Abstracts must digest the project's results and the investigator's conclusions. Applications must be submitted on official forms, which may be obtained from the Department of Medical Education at the AHA national office, 44 East 23rd Street, New York, New York 10010.

Applications for cardiovascular films and scientific exhibits to be considered for presentation at the sessions also may be secured from the American Heart Association national office and must be mailed by June 7.

Dr. Joseph A. Quigley, Mt. Healthy, director of the Health and Safety Division at National Lead Company of Ohio, was honored by the American Academy of Occupational Medicine, when it presented him an Award of Merit in Washington, D. C.

Dr. Bernard M. Mansfield, Galion, was honored at a meeting of Olentangy Chapter of the Daughters of the American Revolution for his activities in preservation of community history, particularly in his contributions to founding the Galion Historical Society.

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For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle

927-8

What Has the AMA Done for You?

At the 1968 Annual Conference for County Medical Society Officers, sponsored by the Ohio State Medical Association in Columbus on February 25, David B. Weihaupt, Chicago, Field Representative for the American Medical Association, spoke, using the above title as his theme. His talk was a storehouse of information of utmost interest to physicians, and in order to concentrate on salient points the following excerpts are presented.

QUESTIONS ARE ASKED many thousands of times per year primarily by physicians: What is the AMA doing? What has it ever done for me? What's going on at 535 North Dearborn Street? What am I getting for my dues?

These questions are rightly asked. A membership card in the AMA does not automatically endow its holder with a sophisticated knowledge about the functions and the purposes of the AMA. The answers to these questions are available, throughout the course of a year, but they are supplied on a piecemeal basis of letters, pamphlets, and literature that come through the mail.

The AMA is a tremendously functionable and productive association doing an enormous job in serving the profession and the people of this country.

In the following information, I would like to ask you to read into the facts and figures, the benefits that you have and will derive from what the AMA is doing, for I cannot associate all of this to each of you individually.

The general purpose of the Association is to promote the science and art of medicine and the betterment of public health. I am not here to defend, apologize, or excuse AMA, its policies, or philosophy which may be different from yours, nor the lost battles of the past. We have lost battles to the 187 billion dollar Federal Government. AMA does not have the staff, time, or the money to wage a multimillion dollar battle against federal control.

Let me give you the following information and facts.

There are approximately 317,000 physicians in this country of which 215,000 are AMA members.

Of these, only 164,000 are dues paying members.

Approximately 28 per cent of the total budget is from physicians' dues. The remainder - - - from advertising and exhibit revenues.

Your dues of $70 would have to be over $220 to make up the needed funds to operate, if it weren't for the abilities and the hard work of the people at AMA in obtaining these revenues.

Approximately $5 million of the budget goes for salaries for the 922 employees. In this group are physicians, attorneys, chemists, journalists, biostatisticians, and accountants, who are high calibre people.

The AMA has annual real estate taxes of approximately $275,000 and social security payments of approximately $350,000.

The AMA is one of the world's largest publishers, and about $12 million of the budget goes into paper, printing, and mailing. I ask you to consider all the following figures on a basis of a cost of 11 cents per page to produce and mail. These costs, by the way, are up approximately 181 per cent in the last seven years. I would like you to consider the following as benefits not only to the general public, and AMA members only, but also as the benefits derived by nonmembers, for AMA serves the profession.

Three Million Pamphlets

Since 1960, over three million pieces of literature have been sent to students of medical schools.

The *AMA News* has a circulation of approximately 340,000 and is published each week. That's about 17 million newspapers per year. Each physician, member or not, members of Congress and major newspapers all over the country receive copies.

The AMA has approximately 3,500 different pamphlets on, child care, health education, health tips, sex education, and many others. It sends out over 100,000 copies per year of each of the major pamphlets and thousands of the others.

It has sent out over two million copies of the *AMA First-Aid Manual* in the past several years.

It publishes ten specialty journals with a circulation of 226,000 and recently released 311,000 pieces of mail to physicians in this country on health education materials.

Every two years it publishes the *AMA Directory*, 6,500 copies, which contains biographical and educational data on every licensed physician in the United States. The Directory is a three-volume set, sent to every state and county medical society, all journal editors, and the libraries of 94 medical schools.

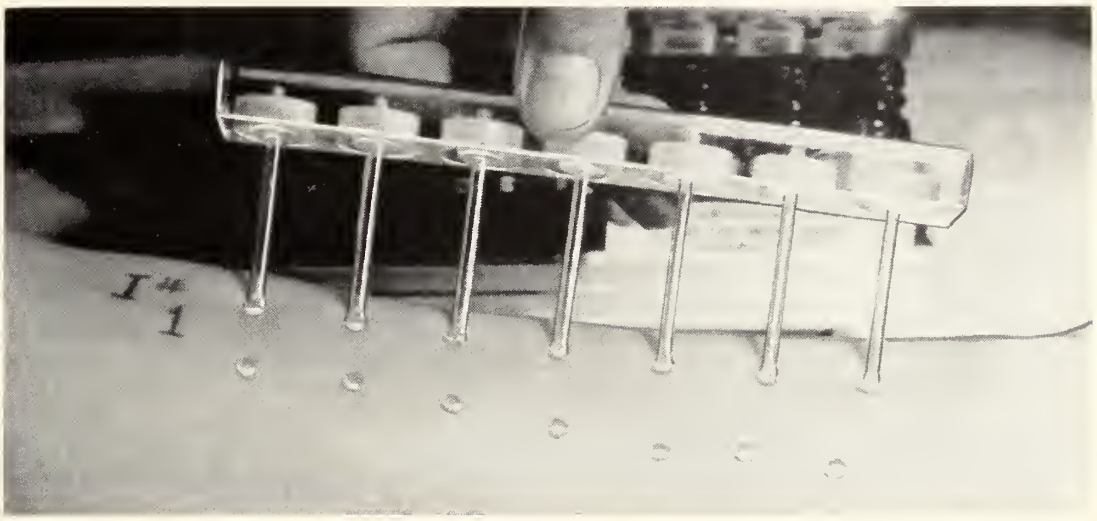
The magazine *Today's Health* comes out monthly with a circulation of 700,000, a mailing of about 8½ million magazines each year.

"Horizons Unlimited" on health careers has been sent in quantities of tens of thousands to schools, colleges, and medical societies free. In Ohio alone, over 3,000 were delivered to county medical societies and the State Association.

In one month, 30,000 copies of the booklet "Selective Military Service and the MD" were sent to medical schools and other organizations requesting it.

In addition, the books *Current Medical Terminol-*

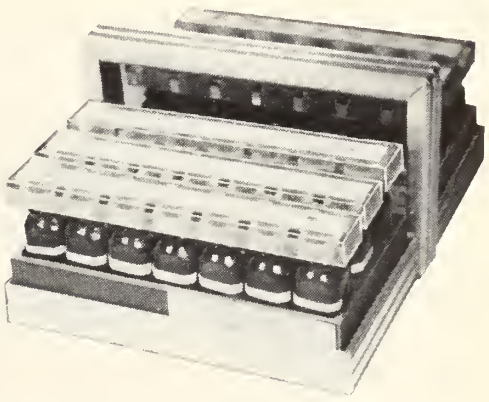
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The prescription treatment sets are sent to you in four vials of graduated dilutions to support a conservative dosage schedule and to permit a dosage adjustment if indicated by your patient's sensitivity.



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Each vial is made to the individual doctor's prescription of antigens, creating a constant control of therapy, reflecting patient reaction and tolerance. This enables the doctor to adjust dilution and add or delete antigens with each vial as indicated by patient's reaction. ALO maintains a permanent, fast referrence patient record of each prescription.

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ogy and *New Drugs* are sent out by the thousands each year.

The Journal of the American Medical Association has a circulation of 219,000 and comes free to all members of the AMA. *JAMA, Today's Health, AMA News,* and the specialty journals cost the AMA about $50 per year to send to each physician member. The AMA specialty journals and *JAMA* are printed by the McCall Corporation, in Dayton. With all these publications and materials distributed, the members of the AMA carry some of the burden of the nonmembers.

Each year, thousands of manuscripts are submitted for review, and actually, the AMA is able to publish over 1,000 annually.

The AMA checks over 500 medical publications each month for useful information to relay through its publications.

In 1967, over 25,000 copies of "Winning Ways with Patients" were sent free.

This is actually a small percentage of the tremendous publishing, printing, and mailing burden that the AMA has every year, and this is done for the benefit of the public, the medical profession, component societies, and other organizations in the country. The natural question is — Why all this paper?

The reason is that these publications have been asked for by the 242 members of the AMA House of Delegates, by the public of this country, the schools of the nation, allied health professions and health institutions, and also the more than 1,900 state and county medical societies. These materials are published as answers to the search of these organizations for information. Literally thousands of pieces of different types of material are relayed to component medical societies — information on legislation, state laws, federal laws, plans, and programs of the AMA and just normal every day correspondence between component organizations. This represents a lot of time, work, and paper, but this is the responsibility of the AMA to the people of this country. Who else but the AMA is more qualified, more dedicated, more capable, and more unbiased to do this job for the physicians and the people of this country — and the job must be done.

I have given a small packaging of the total statistics available and what actually goes out of AMA. Now here are some of the things that come into the AMA.

In one day, there are 1,000 long distance telephone calls.

23,000 Letters Daily

A total of 23,000 pieces of first class mail come into the AMA every day and this is about six million pieces of mail every year. Consider the fact that to serve membership and the public, it takes people to receive, open, distribute, reply to, and file this enormous load of correspondence.

Each year the AMA receives 30,000 requests from the general public for help and information, and it gets many thousand more requests for information and help from physicians — not just members.

In the card catalog of physicians, there are 6,000 changes every week in physicians' home and office addresses.

The Archives Library of the AMA receives in an average month 2,400 research requests and 750 requests for books. It loans out close to 400 library items; photocopies and sends out (each month) approximately 19,000 pages of material.

In the library itself, there are 40,000 books, 2,500 periodicals, and 610 magnetic tapes with medical information.

In the film library, there are 500 films available for the public, medical societies, and individual physicians. A cross-file in the film library has over 7,000 cards. Although you may never use these benefits, tens of thousands of people do each year, and will in the future. They are available for you.

The film "Medical Careers" has been shown 90,000 times and the film "Careers Unlimited" has been shown over a quarter of a million times. A new film called "Faith" is being made and publicity spots have been sent out to over 2,000 radio stations. Recently, the AMA sent out health tips to over 600 TV stations and 2,600 radio stations — a 60 second spot for the public benefit.

In the past year, the AMA has arranged for over 1,300 health films to be shown 32,000 times at 7,000 appearances before 13 million people.

Conceivably, these are very boring figures, but if you consider them carefully, you will see the enormous job that the Association is doing in almost all fields of medicine. It would be a wonderful thing if the general public had an awareness of this enormous job. Then the many misconceptions about the AMA would most certainly be cleared up.

The staff has designed and built 110 medical exhibits for use by the public, medical societies, and medical schools. Four of them were at the Ohio State Medical Association 1967 Annual Meeting and it looks very promising that there will be more than that at the 1968 meeting in Cincinnati.

Many of you are familiar with the page, the "Legislative Roundup" which goes to all state, county medical societies, and physician leadership in the states. It is a one-page piece with a brief summation of the status of current legislation in Washington.

Study TV Plan

It is hoped that in the near future, the AMA can initiate a new program called "Report of the Nation." It will be a coast to coast one-hour network TV

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2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily
Available:
Bottles of 100, 500, 1000.

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HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
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EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
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Android —E

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Methyl Testosterone . . 2.5 mg
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INDICATIONS Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis **DOSE**. One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**. In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS**. See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

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program put on three or four times a year by the AMA to provide accurate and truthful information to the public.

Here is more information on what goes on in the AMA.

There are over 1,000 meetings held every year and over 800 physicians serve without pay on the 80 commissions, councils, and committees. That's one physician for every 200 doctors in the country. There are 80 committees, 16 councils, 4 commissions, 22 scientific sections, 10 specialty journals, 50 departments and 8 divisions. The divisions are the Communications, Law, Management Services, Scientific Activities, Scientific Publications, Health Service, Medical Education, and Field Service. Under these are the Council on Drugs, Committee on Quackery, Committee for Research on Tobacco and Health, Committee on Cutaneous Health and Cosmetics, and on and on to a total of 80. All of this created by the actions of the House of Delegates, for the needs of medical societies and the general public and the profession.

Throughout the course of the year, the AMA sponsors 400 scientific exhibits at the Annual and Clinical Sessions, and 300 exhibits on new drugs. There were 39,000 registrants at the 1967 Annual Meeting in Atlantic City and these people had an opportunity to see the latest developments in American medicine.

Millions in Student Loans

You have all heard of the AMA-ERF Student Loan Program, sponsored by the AMA. Under this program, the AMA has arranged over $45 million in loans, involving 28,000 separate loans to 19,000 medical students, interns, and residents. In Ohio alone, over 1,300 loans have been arranged encompassing over $1,500,000 to medical students. The average physician contribution in this country is $2.50. Since 1955, the AMA has received and distributed over $35 million to medical schools in this country. Councils and Committees are also working hard to increase the enrollment in medical schools, to expand facilities of those that exist, and to assist in the forming of new medical schools. Sixteen are now in the making, and AMA has made major contributions to their beginnings.

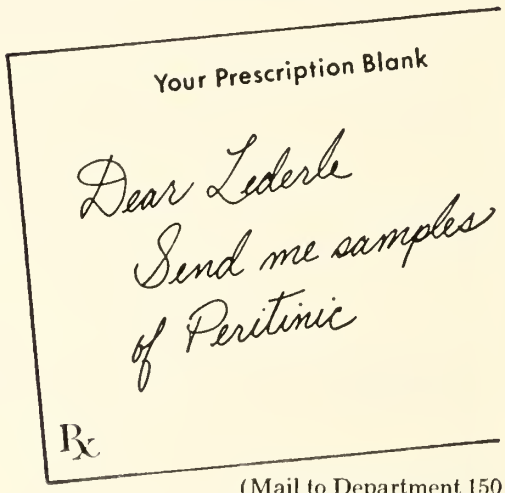
Woman's Auxiliary with headquarters at AMA has received and distributed over $3 million for medical schools and $4 million to the student loan program.

AMA also has available some direct benefits, such as the AMA Retirement Program and the Disability Program that physician members can take advantage of.

The Speakers' Services Department writes and supplies speeches and other materials for research for physicians throughout the country and officers of the

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* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

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● Elemental Iron (as Ferrous Fumarate)	100 mg
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Association. Building plans, partnership agreements, and a variety of other services are at the disposal of physicians.

The Communications Division has literature, program aids, films, speeches, press materials, and other services available to state and county medical societies, as well as physicians. For the director of the Communications Division, there is an Advisory Committee which consists of state executive secretaries. Mr. Hart Page is a member.

The Department of Medicine and Religion has a four-man staff working with medical schools, theological seminaries, hospitals, physicians, and clergy in a very successful attempt to bring together the healing of the body and soul. Dr. George Petznick, of Cleveland, has served on this committee since its beginning.

Biomedical Research

You have heard of the American Medical Association Institute for Biomedical Research. This was created by the AMA House of Delegates. There are 30 scientists doing research in immunology, medical ecology, virology, molecular biophysics, regulatory biology, and neurobiology. This too is a service to all mankind and the profession.

Project Vietnam is a program initiated by the federal government, which was not functioning too well, naturally, and the government asked the AMA to take it over, naturally. It is a program whereby physicians volunteer to go to Vietnam and serve the civilian public of that nation. In the two years AMA has been handling the program, approximately 293 physicians have served in Vietnam. In one month alone, 75 inquiries and 28 applications were filed. This month (February) there are nine physicians going to Vietnam to serve under this program.

One of the most active divisions of the AMA is the Law Division, which supplies to all departments and the Board of Trustees and the physicians throughout the country, legal opinions, guidance, information on medical liability, taxation, insurance, advertising, copyrights, and specific information on liable and slander. Thousands of physicians write every year and receive guidance on state problems, retirement problems, partnership agreements, and federal, and state laws. Under the Law Division, the Department of Investigation wages a relentless battle against quacks and charlatans throughout the country, as a service to the public health, and the profession.

Let me briefly give you the box score of the AMA Political Action Committee, which was involved in 131 Congressional races in 1966. Of those, 104 races were successful. It was involved in 15 Senate races and won 13 of them and some of these major victories were made in Ohio as a



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Pectin ..... (2½ grains) 162 mg.
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result of the tremendous and effective effort of the Ohio Medical Political Action Committee.

Voice in the Capital

And now after all this information about the AMA and its services to the physicians and the public of this nation, I would like to discuss that which the press dearly likes to write about as a major and almost total function of the AMA — the Washington Lobby!

Some say all it does is try to enhance the income of physicians of this country. They write about this group, the lobby, as a multimillion dollar organization, which, it is written, hates children, old people, the handicapped, and the poor. This is a huge, unjust burden which the AMA must carry. When this lobby tries and succeeds in excluding the disabled persons from the new social security amendments, the press of this country says generally that physicians hate the handicapped. In truth, these unfortunate people are not only treated at a decreased charge by physicians, but they're also covered under Title XIX of Medicare, and several other federal and state programs. This is a prime example of federal duplication.

Only a fraction of one per cent of the budget of the AMA goes to lobbying. Let me tell you more about this so-called multimillion dollar lobbying staff. In truth, it consists of four full time registered lobbyists. Yes, the AMA has only four men in Washington compared to Labor's 125 registered lobbyists and 300 unregistered lobbyists. Each of our men has 12 Senators and approximately 100 Congressmen to learn about, work with and convince. A small force indeed! But don't let me minimize their abilities, their influence, their effectiveness and their successes. They do an outstanding job and this can be proven by past and present successes in Washington. It can also be proven by some of the adverse publicity. There were some rather uncomplimentary quotations in one of the nation's leading magazines not too long ago.

Senator Stephen Young, (D-Ohio), referred to this AMA lobby in the November, 1967 edition of *Playboy* magazine as follows: "One of the slickest, best financed in the nation" and "it has been the spendingest lobby in Washington in recent years." Not only is his choice of words uncomplimentary but inaccurate.

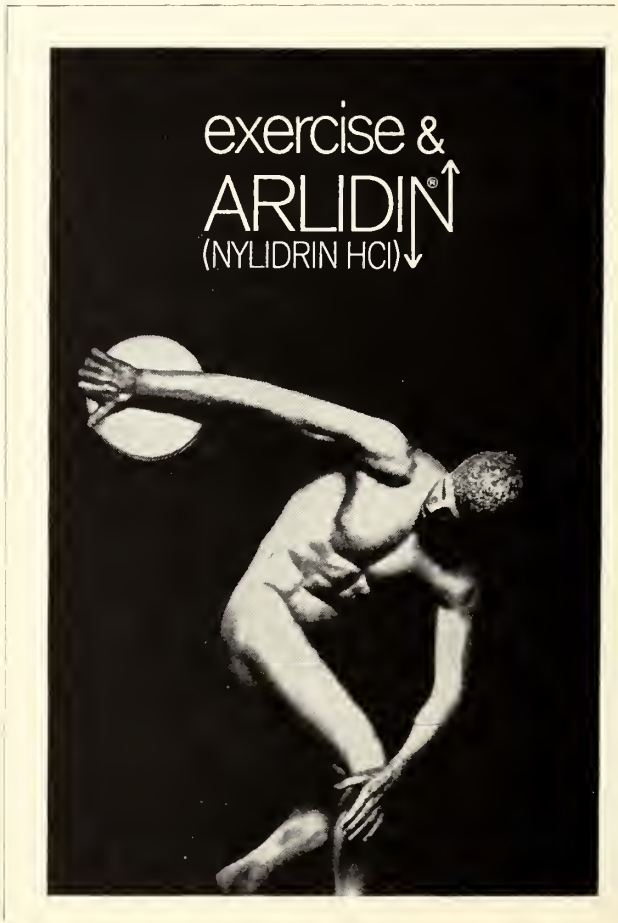
Let me give you some information on what this lobbying staff is really up against and what it really does. In the 89th Congress, there were 26,500 bills introduced of which 1,600 had health implications. The AMA offered information and opinions on 33 of these bills and contrary to popular belief, favored 21, partially favored 5, and opposed only 7. In the first session of the 89th Congress, there were 850 bills with medical implications, but in the first session of the 90th Congress, there were over 1,126 bills pertaining to health, and this can give some idea of what is coming up in the second session of the 90th Congress.

The AMA has one man in Washington to analyze these 1,600 bills of the 89th Congress and the 1,100 bills so far this year of the 90th. Back in Chicago, there are three men to corrolate policy and position and testimony on these bills and to establish a position as to the impacts of the legislation on physicians of this country and the general public. I wish to point out that a great deal of the work done in Washington by our staff is for the benefit of science of medicine and that these men supply basic medical information to members of Congress, for themselves and for the people of their districts. They help the legislators obtain family physicians when they move to the District of Columbia, or find nearby specialists for them or for their families or friends, if needed.

Some Matters Faced

Some of the fights that these men now face in Washington are as follows:

Presently, the Hart Bill is being considered — a bill that says physicians cannot own an interest in a



pharmacy and that they cannot dispense drugs or other medical devices at a profit, only at cost, not encompassing overhead.

There are attempts for federal inspection of your records, chiropractic inclusion in Medicare, a bill of adult health protection, a bill for drugs to be included under Part B of Medicare. Other pieces of legislation considered are those which call for federal inspection of animal research facilities, legislation on medical device standards and literally hundreds more.

A new problem in Washington is that the Internal Revenue Service is imposing a regulation on unrelated income. This would impose a 48 per cent tax on profits received from advertising and exhibits. This primarily is directed towards the American Medical Association and could also be a burden on the state and county medical associations. It is our belief that this is directed towards the AMA for the specific purpose of cutting the budget down low enough to eliminate the Washington lobby and legislative efforts.

Thus far the federal government's medical programs now cover medical care of one type or another for 50 million of the 200 million Americans in this country. The AMA does not, of course, oppose all bills in Congress. It has a fine record of introducing legislation for the betterment of public health, and is currently favoring legislation regarding air and water pollution, highway safety, and general health standards.

Of course, people close to medicine refer to the great legislative failure which was the passage of the Medicare law. But the opposition says that organized medicine held off the passage of this law for 30 years. Conceivably, this was a benefit to the physician members, in that prior to the passage of Medicare, the physicians were paying $290 Social Security. This year a physician will pay $499 Social Security for a difference of $209 per year more since the passage of the law. Multiply that $209 savings by the number of years you have been in practice. This is a federal method of using figures. Let me say that AMA winning the Medicare battle for 30 years conceivably has saved you considerable monies.

Service in the Field

Now, a little about my Division — the Field Service Division. The Washington office is part of this Division and we headquarter in Chicago. There are 12 men covering the United States, also Puerto Rico (The Virgin Islands) and as far away as Alaska and Hawaii. We work in a person to person contact with staff and leadership of state and county medical societies. I personally cover Ohio, Kentucky, Pennsylvania and West Virginia. A great percentage of my function is in the legislative and liaison area. In our work, we interpret and promote the activities and services of all AMA departments to component societies and, in turn familiarize the AMA with the programs, problems, needs, and opinions of component medical societies, and the public, physicians, and physician leadership.

In conclusion, what does the AMA do for you and the public in this country? Actually, the American Medical Association and its work are felt in the toothpaste you use in the morning, the soap, food you eat, the car you drive, the seat belts you put on, the sports your children and you play, the school lunch program, women's cosmetics, dyes, clothes, the air you breathe and the water you drink, not to mention the preceding information that I supplied in this presentation.

But when I am asked "What do I get for my dues?" If I don't have time to give a speech, my short reply is "Nothing." Who said that the $70 in dues would come back to the member January



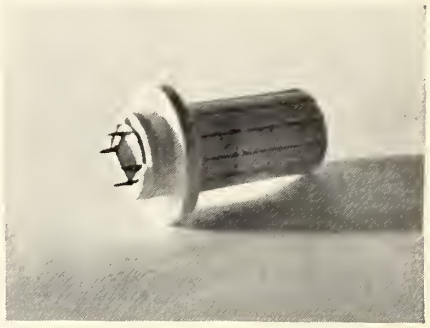
1 each year as a short term capital gain. The AMA is not an investment house. The joining of the AMA, state medical association and your county medical society is another service that the physician performs not only to his profession but for the betterment of public health.

Many physicians do more, in their contributions to these organizations by serving on committees and councils and as officers. But, let me say, if all this information and all these facts and figures do not convince you of what we are doing for you, let me ask you this favor. Read with a critical eye the newspapers and the magazines of this country that misshape these figures and our work. And, if you still believe them, let me ask you this. Don't speak out against medicine, the AMA, state and county medical society. Don't add credence to the cries of the enemies of medicine by lending them your voice and opinions which are formed by the newspapers. Don't quote your enemies, quote your friends. Don't criticize with inaccurate information and help the enemies of medicine in eliminating the private practice of medicine and organized medicine as we know it today. They know we are divided. They are not.

Dr. Clarence F. Murbach, Archbold physician and surgeon of long standing, now retired, was named Citizen of the Year by the Archbold Lions Club.

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Make tuberculin testing routine with every physical examination.



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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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Ad Astra

Kenneth H. Abbott, Sr., M. D., Glendale, Calif.; Loma Linda University School of Medicine, 1936; aged 56; died March 3; former member of the Ohio State Medical Association; diplomate of the American Board of Psychiatry and Neurology, and the American Board of Neurological Surgery; associated with a number of professional organizations. A practitioner in the field of neurosurgery, Dr. Abbott was in the Columbus vicinity from 1948 to 1958. In California he was cochairman of the Department of Neurosurgery at Loma Linda University School of Medicine. Survivors include his widow, a daughter, and three sons, among them Dr. Kenneth H. Abbott, II, Houston, Texas.

James Clarence Bergmann, M. D., Dayton; Marquette University School of Medicine, 1961; aged 37; died March 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Bergmann entered practice in the Dayton area in 1962 after taking internship training at St. Elizabeth Hospital. Surviving are his widow, four children, his parents, and a sister.

Alfred John Gericke, Sr., M. D., Cleveland; Western Reserve University School of Medicine, 1919; aged 75; died March 16; member of the Ohio State Medical Association and the American Medical Association. A practitioner of some 46 years standing, Dr. Gericke's field was general practice and dermatology. Among affiliations, he was a 32nd Degree Mason. Survivors include his widow, a son, and two brothers.

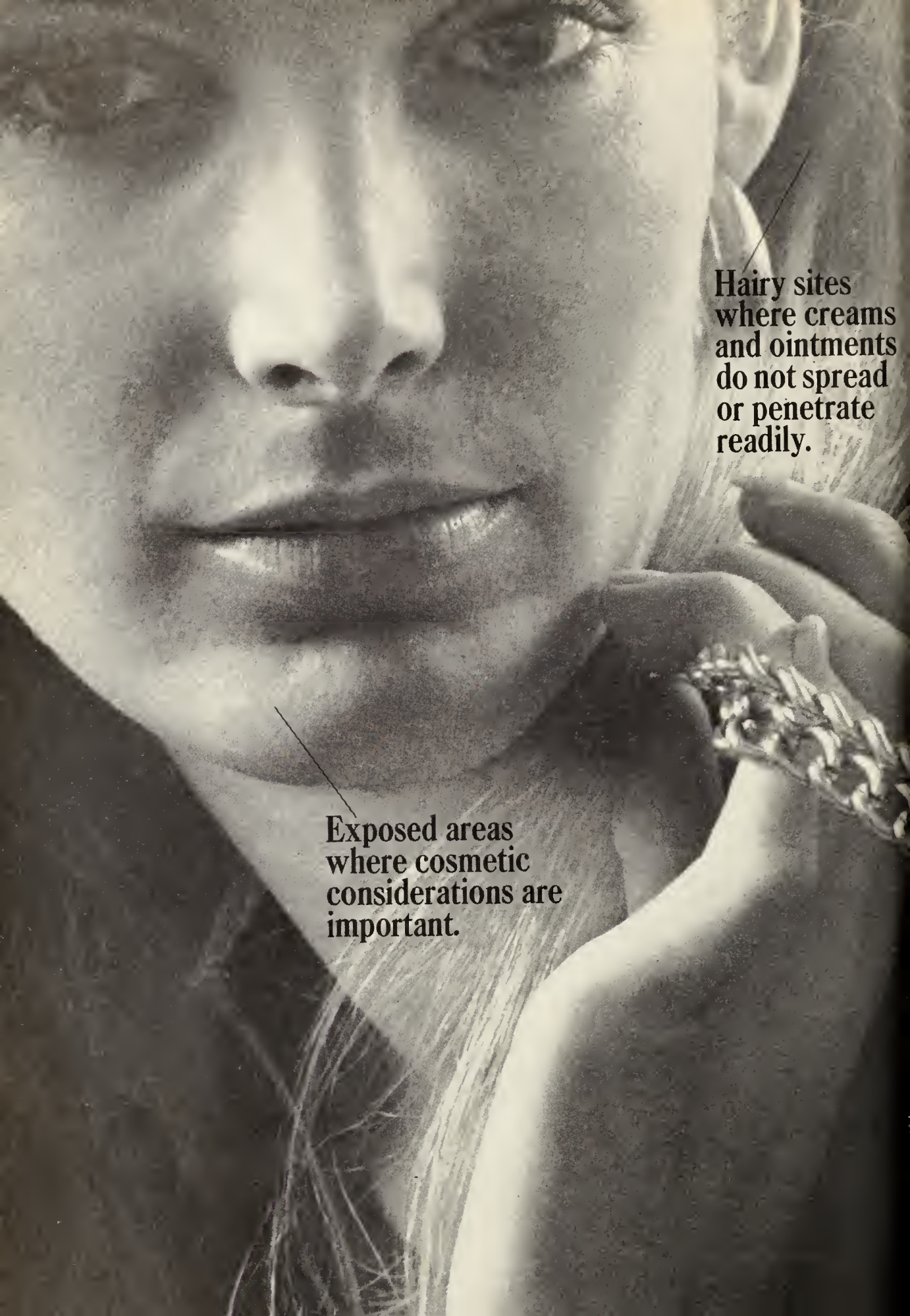
Earl Charles Horne, M. D., Gladwin, Mich.; Western Reserve University School of Medicine, 1909; aged 87; died March 7; former member of the Ohio State Medical Association. Dr. Horne formerly practiced in Cleveland and left there in 1955 to practice in the Michigan community. Surviving are his widow, a son, two daughters, and five sisters.

John E. L. Keyes, M. D., Euclid; University of Toronto Faculty of Medicine, 1908; aged 80; died March 22; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology; Fellow of the American College of Surgeons; diplomate of the American Board of Ophthalmology. A practitioner of long standing, specializing in ophthalmology, Dr. Keyes came to the United States from Canada in 1923. He practiced both in Youngstown and in the Cleveland area and was on the faculty of Case Western Reserve University School of Medicine. During World War I he served with the Canadian forces, and during World War II with the U. S. Medical Corps he attained the rank of lieutenant colonel. Surviving are his widow, a son, two daughters, and a step-sister.

Wilbert Hersman McGaw, M. D., Cleveland; Western Reserve University School of Medicine, 1925; aged 70; died March 16; member of the Ohio State Medical Association, American Medical Association, Clinical Orthopaedic Society, American Academy of Orthopaedic Surgeons, American Association for the Surgery of Trauma, American Rheumatism Association, American Orthopaedic Association; Fellow of the American College of Surgeons; diplomate of the American Board of Orthopaedic Surgery. A practitioner of long standing in Cleveland, Dr. McGaw was head of the orthopaedic department at St. Luke's Hospital until his retirement a few years ago. During World War I he served with the Lakeside Unit in Europe, and during World War II again served with the Medical Corps. Among survivors are his widow, a son, and a daughter.

James Edward Miller, M. D., Toledo; Western Reserve University School of Medicine, 1935; aged 57; died March 16; member of the Ohio State Medical Association, Central Association of Obstetricians and Gynecologists; Fellow of the American College of Obstetricians and Gynecologists, and of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Dr. Miller was a practitioner of long standing in Toledo. In addition to his professional affiliations, he was a member of the Lutheran Church, the Inverness Club, and the Kiwanis Club. Surviving are his widow, a son, and a daughter.

Lemuel Ansel Woodburn, M. D., Urbana; University of Cincinnati College of Medicine, 1921; aged 76; died March 5; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A native of Urbana, Dr. Woodburn served virtually all of his professional career in that vicinity. He was a veteran of World War I, a member of the American Legion, and a member of the Methodist Church. Among survivors are his widow, a son, Dr. James D. Woodburn, of Columbus, and a stepson.


Hairy sites where creams and ointments do not spread or penetrate readily.
Exposed areas where cosmetic considerations are important.

An invisible topical

for many dermatologic problems



Moist or intertriginous areas where drying action is desirable.

See last page for contraindications, precautions and side effects.

Structurally unique topical steroid in propylene glycol vehicle produces rapid response in many dermatoses.

Synalar Solution produces rapid antiinflammatory, antipruritic action through its unique topical corticosteroid, fluocinolone acetonide. The propylene glycol vehicle provides additional benefits for therapy at problem sites where it is difficult to achieve contact between the lesion and medication—or where creams or ointments may make the lesions worse. Synalar Solution has proved particularly valuable in the symptomatic treatment of seborrheic dermatitis of the scalp, nasolabial folds, eyebrows, ears, and in flexural folds such as the axillae, inframammary, umbilical and anocrural areas. It has also been reported to achieve excellent results in the adjunctive management of atopic dermatitis, contact dermatitis, neurodermatitis, nummular eczema, psoriasis, and sweat retention syndromes in these problem sites.

Penetrates the hairy sites.

In many areas of the body, hair gets in the way of treating the underlying dermatitis. The propylene glycol vehicle of Synalar Solution permits penetration and dispersion at sites where creams and ointments do not readily penetrate. May be applied without matting of hair.

Ideal for moist or intertriginous areas.

Propylene glycol is strongly hygroscopic and is especially useful where sweat retention is a problem. Its low surface tension permits easy spreadability in difficult-to-treat body areas. A number of studies have also shown that propylene glycol has inherent antimicrobial activity.



Cosmetically acceptable for exposed areas.

The propylene glycol vehicle of Synalar Solution possesses many useful cosmetic properties. Clear and greaseless, it is not sticky or messy, will not stain clothing or skin. In exposed areas of the body where cosmetic appeal is important, Synalar Solution shows nothing but results.

Economical—a little goes a long way.

Because of the properties of propylene glycol and the milligram potency of fluocinolone acetonide, a small quantity of Synalar Solution goes a long way. Also, the prescription price of a 20 cc. plastic squeeze bottle of Synalar Solution is surprisingly low. Thus, your patients obtain economy with the proved efficacy of a potent, truly advanced topical corticosteroid.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

Availability: Synalar (fluocinolone acetonide) Solution 0.01% in a propylene glycol vehicle with citric acid as preservative. 20 and 60 cc. plastic squeeze bottles. *Also available:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

Synalar®
(fluocinolone acetonide)
Solution
0.01%

An invisible topical



Mobile Unit Helps Cleveland Area Physicians in VD Diagnoses

Effectiveness of a mobile unit for the diagnosis of venereal disease is demonstrated in the Cleveland area. Since November of 1966, the Cleveland Division of Health has made available to the physicians of Cuyahoga County a mobile darkfield microscopy unit for the immediate diagnosis of primary and secondary syphilis.

The significant increase in early infectious syphilis in the area, as well as in other large metropolitan areas, is indicated by a reported 416 cases of lesion syphilis during 1967 in Cleveland alone. Health officers point out that in recent years many physicians have been faced with the dilemma of making a diagnosis of lesion syphilis due to the changing and atypical manifestations of luetic lesions. They further declare that too often a serology is the only available and reliable tool for making a diagnosis of infectious syphilis. However, many primary lesions are present with a negative serology, and, in secondary syphilis the prozone serological phenomenon may obscure the diagnosis by producing a false negative serologic test result.

Since notification of the darkfield service of the Cleveland Health Division appeared through the *Bulletin* of the Academy of Medicine (November, 1966) some 146 requests for the unit were received. Of examinations performed, 54 specimens were positive for Treponema pallidum.

The following summary of a case follow-up illustrates effectiveness of the service. A married woman came to a doctor's office complaining of a genital lesion. The mobile darkfield unit was called and Treponema pallidum was identified. The patient was given initial treatment and a confidential interview regarding contacts was conducted in the physician's office. As a result of the epidemiology of this one case, seven new cases of infectious syphilis were uncovered. Ages of the patients ranged from 20 to 35 years, and five of them were married. In addition, preventive treatment was administered to 12 contacts, many of whom undoubtedly would have developed syphilis. Nine other persons also were examined to remove doubt as to infection.

Health officers state that the mobile darkfield service allows the physician to make an immediate and positive diagnosis and administer immediate treatment. In addition, the physician has available a representative of the Division of Health, especially qualified to investigate the source and possible spread of syphilis. Health officers believe that this kind of cooperation between physicians in practice and local health departments will lead to control, and hopefully eventual eradication of the disease.

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Bellaire Physician Is Appointed To the State Medical Board

Governor James A. Rhodes recently appointed Dr. Peter Lancione, of Bellaire, to the State Medical Board of Ohio, to serve a term running to March 18, 1975. He succeeds the late Dr. Domenic A. Macedonia as a member of the Board. Dr. Lancione is a native of Bellaire and has been a practicing physician there since 1937.



Peter Lancione, M. D.

He received his early education in the Bellaire public schools and was awarded a B. A. degree at Ohio State University in Columbus. In 1936 he was awarded his M. D. degree at Jefferson Medical College of Philadelphia. Internship followed at Wheeling Hospital, Wheeling, W. Va.

A general practitioner, with particular interests in radiology, Dr. Lancione has long been a participant in professional activities. He is a past president of the Belmont County Medical Society, and a past president of the medical staff of Bellaire City Hospital. He has long been a member of the Ohio State Medical Association and the American Medical Association. In the general practice organization field, he is a member of the Ohio Valley Academy of General Practice, a member of the Ohio Academy of General Practice, and is serving on the Membership and Credentials Committee of OAGP. His membership also extends to the American Academy of General Practice. He is also a former member of the State Board of Rehabilitation.

During World War II, Dr. Lancione served in the Army Medical Corps, attained the rank of major, and was awarded the Bronze Star. Other affiliations include memberships in the Elks Lodge, the Veterans of Foreign Wars, American Legion, and the Sons of Italy. He is married to the former Alice Morrison, of Colerain, and is the father of two children.

Cleveland Immunity Study Supported By Local Medical Foundation

An article entitled "Cleveland Study on Immunity" in the March issue of *The Journal,* beginning on page 301, reported progress on an extensive Case Western Reserve University School of Medicine project, supported in part by the U. S. Public Health Service.

Attention has been called to an omission in the article in regard to parts played by the Academy of Medicine in Cleveland and its members.

Actually, the Cuyahoga County Medical Foundation which was organized by the Academy of Medicine of Cleveland contributed $29,032.00 to support these studies. This Foundation, with the Academy, carried out the amazingly successful Sabin Oral Sunday polio immunization program in Greater Cleveland in 1962.

The SOS polio program which generated the funds was undertaken on a voluntary basis by 2400 physicians of Cuyahoga County and by countless other volunteers. The Cuyahoga County Medical Foundation was created as an independent physician-supported educational, scientific, and charitable foundation.

The Journal staff regrets this omission of salient information, and is glad to publish this additional data to set the record straight.



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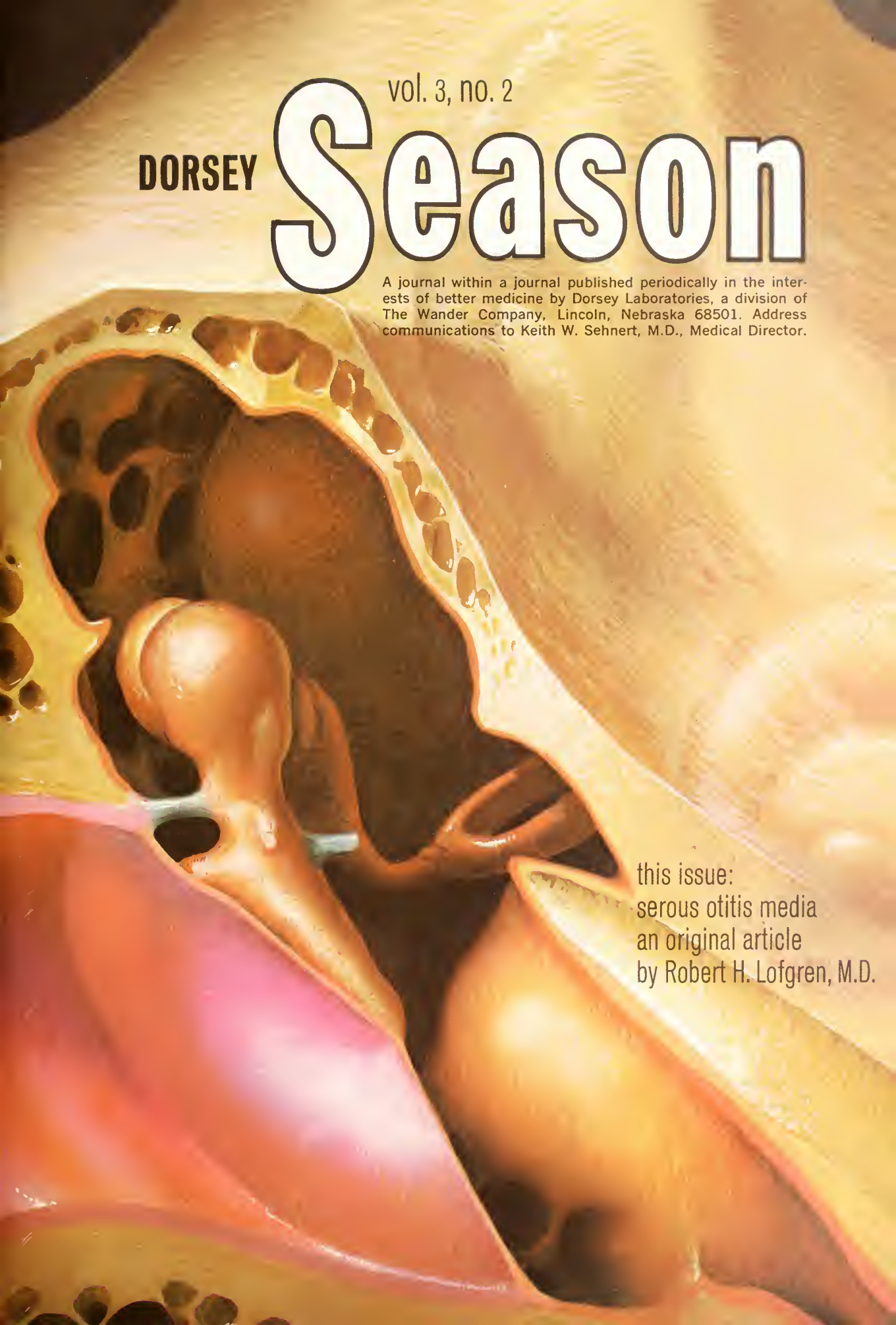
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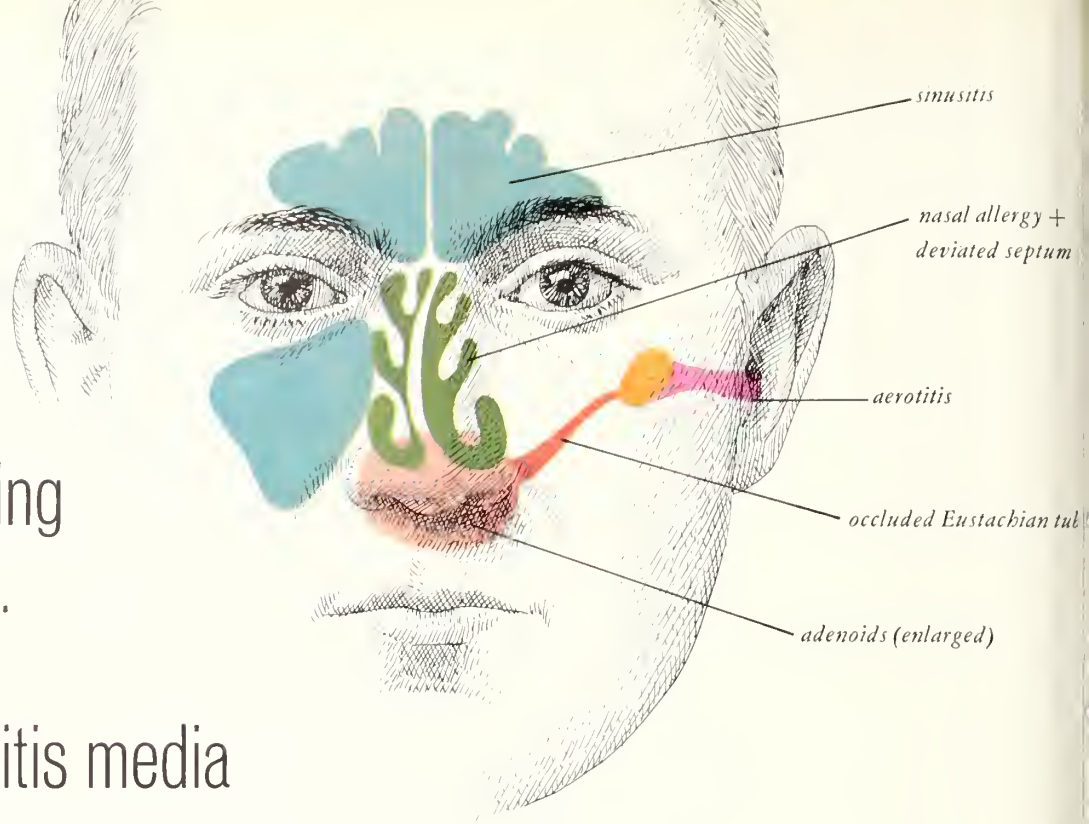
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this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



Normal *Acute Serous* *Acute Purulent* *Chronic Serous*

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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Activities of County Societies...

CUYAHOGA

"The Aged Patient" was the topic for the April 17 meeting of the Academy of Medicine of Cleveland, as announced in the *Bulletin*. The evening meeting was held in the Academy auditorium.

Following are topics of discussion and speakers:

Dr. Joseph M. Foley, director of the Division of Neurology, University Hospitals of Cleveland, moderator.

"The Biology of Aging," Dr. Robert R. Kohn, associate professor of pathology, Case Western Reserve University.

"Some Specific Medical Problems in the Aged Patient," Dr. Amasa B. Ford, assistant professor of medicine, Western Reserve.

"Aging," Dr. Ewald W. Busse, The J. P. Gibbons Professor of Psychiatry, Duke University School of Medicine.

FRANKLIN

The Academy of Medicine of Columbus and Franklin County and the Columbus Bar Association held their eleventh annual joint meeting on April 16. The evening at the Imperial House North, in Columbus, began with a social hour and dinner.

The program announcing the meeting listed the following members of a panel for discussion of the topic, "Pre-Trial Arbitration": Dr. W. Thomas Washam, Columbus, physician-attorney executive secretary of the State Medical Board of Ohio; Dr. Louis K. Collins, Glassboro, N. J., practitioner and president of the Medical Society of New Jersey; Dr. Ian M. Chesser, Tucson, Arizona, chairman of the Medical Economics Committee and the Medical Legal Committee of his county medical society; and Robert M. Backes, Trenton, N. J., attorney and counsel to the Medical Society of New Jersey.

GEAUGA

The Geauga County Medical Society and the Geauga Community Hospital are jointly sponsoring the Medical Explorer Post in cooperation with the Northeast Ohio District of the Boy Scouts of America. At the February meeting, Dr. Adrian Krudy,



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Principals in Lorain County Symposium



Photo Courtesy Lorain Journal

Program participants in the Lorain County Medical Society's 21st Annual Medical Symposium, from left, are Dr. Fischer, Dr. Ross, Dr. Sherbel, Dr. Horenstein, and Dr. Brucker. Dr. Brown, another participant, is not shown. See accompanying article for details.

discussed the function of the x-ray and the part it plays in medicine.

LORAIN

Members of Lorain County Medical Society, for their monthly meeting were guests of General Motors Ternstedt Division, at the plant location on Route 113 West of Elyria, on March 12, beginning with dinner. Ben V. Myers, M. D., of Elyria, introduced Mr. John Findling, plant manager, who welcomed the physicians.

A brief business session of the Medical Society was held immediately following the dinner, at which time Tong W. Moon, M. D., was elected into Associate Membership.

Following this session, the medical program in operation at the plant was briefly outlined, with details of the insurance forms in use discussed. Opportunity for a question and answer period was also afforded.

A Tour of General Motors plant was then conducted by personnel present, in small groups, which enabled the physicians to appreciate more fully the factors explained and the areas visited.

The Twenty-first Annual Medical Symposium sponsored by Lorain County Medical Society at Oberlin Inn, on April 10, attracted a large attendance of the members and physicians from other societies within the Eleventh District, as well as members of Lorain County Osteopathic Association. Following the policy of previous years, residents and interns of area hospitals were invited as guests of the Medical Society.

The main theme of the Symposium was "Back Pain," and the afternoon session featured a series of lectures and slide presentations.

President D. L. Fischer, M. D., called on the chairman of the Symposium Committee, Maynard J. Brucker, M. D., to introduce the participants.

Arthur L. Sherbel, M. D., head of the Department of Rheumatic Disease, Cleveland Clinic, presented "Diagnosis and Management of Back Pain";

Joseph E. Brown, M. D., head of the Orthopaedic Department at St. Luke's Hospital, Cleveland, spoke on the "Orthopaedic Aspects of Back Pain";

Simon Horenstein, M. D., chief, Neurological Service, Highland View Hospital, Cleveland, chose as his topic "Back Pain and Neurological Disease"; and

Melvin Ross, M. D., assistant clinical professor of psychiatry at Western Reserve University School of

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Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

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Medicine, Cleveland, presented "Psychiatric Aspects of Back Pain."

The Evening Session was devoted to a Panel Discussion of Questions submitted by the audience. The Symposium was acceptable for four hours continuation study credit by the American Academy of General Practice.

MAHONING

The Mahoning County Medical Society was host for the Medical-Legal Banquet held on March 19. A social hour and buffet dinner preceded the meeting in the Mural Room, Youngstown.

Speaker for the occasion was the Rev. Joseph R. Lucas, associate professor of philosophy, Youngstown State University. His topic was "Some Moral and Legal Aspects of Malpractice."

MONTGOMERY

Woody Hayes, Ohio State University football coach, was featured speaker at the second annual Montgomery County Medical Society Father-and-Son Banquet held on February 13. Some 250 persons attended the program at the Sheraton-Dayton Hotel. Si Burick, *Dayton Daily News* sports editor, was master of ceremonies.

The Society held its membership meeting for members and wives on March 21 with dinner and a program at Wright-State University. A welcome address was given by Dr. Brage Golding, president of the university. Doctors were conducted on a tour of the biology department, while the ladies were given a tour of the campus.

SUMMIT

The Summit County Medical Society membership meeting was held on March 5 in the auditorium of Children's Hospital, Akron.

Speaker for the occasion was Jack Geick, marketing director, Non-Tire Operations, Firestone Tire and Rubber Company, who presented a safety program under the title "An Ounce of Prevention."

The Summit County Diabetes Association gave its first annual postgraduate seminar on diabetes mellitus on March 27.

The Akron Obstetrical and Gynecological Society cosponsored the fifth annual Alven M. Weil Memorial Lectureship on March 6 at the Akron City Club. Theme for the program was "The Problems of the Aging Individual," and the following speakers and topics were included:

Dr. Robert B. Greenblatt, professor and chairman, Department of Endocrinology, Medical College of Georgia, "Modern Concepts in the Management of the Post-Menopausal Patient";

Dr. Jessie Marmorsten, clinical professor of medicine, University of Southern California, "Harmonal Therapy in the Management of a Recurrent Coronary Heart Attack in Males";

Walter C. Alvarez, emeritus professor, Mayo Graduate School of Medicine, "Common Problems of Aging and Their Management."

Dr. Greenblatt also gave the after dinner address, using as his topic, "Endocrine Profiles of Some Biblical Personalities."

Dr. William D. Beasley, retiring chief of staff at Community Hospital of Springfield, was honored at the second annual Community Hospital Corporation at Springfield's Wittenberg University. Guest speaker for the occasion was Dr. Charles L. Hudson, Past President of the Ohio State Medical Association and Past President of the American Medical Association, who is now associated with the AMA headquarters in Chicago.

Dr. William A. French was named Citizen of the Year by the Community Betterment Club of Ironton. A practitioner in Ironton since 1934, Dr. French was cited for work in behalf of community betterment through his activities in numerous local organizations. Dr. French has been unable to pursue his practice lately because of ill health.

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Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
2442 Dorman Drive, Portsmouth 45662

THE LILTING REFRAIN refuses to leave me. Over and over, "California, Here I Come" jingles its melodic tones deep into my consciousness. The song started haunting me the day I received the various releases from National headquarters on the forthcoming 45th annual convention of the Woman's Auxiliary to the American Medical Association in San Francisco, June 16 to 20, at the St. Francis Hotel. (I know there's a delightful song about San Francisco too — but 'twas the other one that's hung me up!).

Well, let the melody linger on. . . . It's time to get down to some outstanding facts: This convention is of particular significance to our Ohio Auxiliary because it is Gerby's convention. Gerby, of course, is Mrs. Karl F. Ritter of Lima, and Mrs. Ritter is, of course, President of the National Auxiliary (and past president of our own state auxiliary) which makes it all very exciting, all very newsworthy, all very extra-special! The Ohio delegation will be a mighty proud delegation — proud of Gerby's devotion, competence, graciousness and down-to-earth approach.

There will be a reception on Sunday, June 16, at the St. Francis honoring our National President and the President-Elect, Mrs. C. C. Long of Arkansas. Scheduled from 5 to 7 o'clock, the reception will be open to members, husbands, and guests. This 45th convention will formally convene on Monday, June 17, at 9 A. M. Mr. Philip Lesly, president of the Philip Lesly Company, a Chicago-based public relations firm, and counsel on PR and communications to the AMA, will deliver the keynote address.

Monday's luncheon will honor the leaders of women's volunteer organizations throughout the United States. Featured speaker will be Dr. Henrik L. Blum, clinical professor of community health planning, University of California School of Public Health. He will discuss "Program Planning and Implementation."

Dr. Milford O. Rouse, AMA President, will be the guest speaker at the Tuesday, June 18, luncheon honoring National Auxiliary past presidents and AMA officers and Trustees. At this time, Mrs. Ritter will present the Auxiliary's contribution to AMA-ERF. (Last year's gift totaled $384,649!).

The Tuesday afternoon session will feature a program by the Communications Committee relating to state publications. Following this program which promises to be of tremendous help to state presidents, presidents-elect and state editors, there will be a special showing of films on sex education, drug abuse, physical fitness, and nutrition. This new feature will provide Auxiliary members with a catalog of available health education materials to be used in conjunction with existing Auxiliary programs.

Highlighting the four-day session will be the new mobile demonstration unit called "Homemaking Unlimited." This five-ton coach, sponsored by the School of Home Economics of the University of Nebraska, shows handicapped housewives how they can be self-reliant homemakers despite physical limitations. During convention, the unit will be displayed on Powell Street, across from the St. Francis Hotel. There will be conducted tours of this unique rehabilitation unit.

The Wednesday, June 19, business session will be held from 9:00 A. M. to noon, followed by installation of new officers. There will be a post-convention conference for state Presidents and Presidents-Elect at 2:30 P. M. (This is open to all Auxiliary members.) This conference, usually scheduled

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for Thursday morning, is to be held on Wednesday afternoon to give members free time on Thursday to visit areas of San Francisco. Once again, the National Auxiliary will sponsor a program of daily activities for the pre-teens and teenagers of members and guests. (I do not have details available on that yet, but perhaps I can give more specific information in next month's column.)

Rooms have been set aside for Auxiliary members at the St. Francis and Sir Francis Drake Hotels which will be available on a first-come, first-served basis. Reservations should be made on the official form in MD's Wife and mailed to the WA-AMA Housing Bureau, 260 Fox Plaza, San Francisco 94102. (For hotels other than the two mentioned, it is suggested you consult the *AMA News* and *JAMA.)*

What I have attempted to present here on the National Convention is, of course, no more than a bird's-eye view. To those who can attend, it will be a time of Auxiliary learning and planning, a time of wonderful togetherness and a time for fun too. . . . And an unequaled opportunity to hear some mighty outstanding speakers. . . . And for our own delegation, there's the "piece de resistance" — the annual Ohio Breakfast.

Be on hand to honor Gerby Ritter! It is your state auxiliary's fervent hope that many, many Ohio auxilians will be an eloquent choir singing "California, We HAVE Come"!

Around the State

There were some 90 members and guests at **Allen County**'s March luncheon at the Milano Club. Among the honored guests was Mrs. Malachi W. Sloan, II, state president-elect, who commended the local auxiliary for its community program on venereal disease. Three student nurses, recipients of the group's scholarship loan fund, were introduced: Muriel Luginbuhl of Memorial Hospital; Kathy Roller and Karen Epps of St. Rita's Hospital. Mrs. Blanch L. Markley, interior designer, and a member of the American Institute of Designers, presented a program on ideas in home decorating. "Your home should reflect you and your way of living," she suggested. Mrs. Markley discussed the importance of color and style, the use of personal keepsakes and heirlooms, adding "this is the 'Mix-Age's where many different styles, periods, finishes, and designs can be blended skillfully." Mrs. S. J. Novello was chairman for the luncheon, assisted by Mrs. Donald English, Mrs. James Zulliger, Mrs. Raymond Epstein, Mrs. John W. Burke, Mrs. Nathan Kalb, Mrs. Walter Yingling and Mrs. Raymond Bushong.

Cuyahoga County auxiliary reported that its French Beading class had created a lovely beaded and multi-colored lilac arrangement in a silver vase that was raffled off at the group's Lilac Time Party

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on April 26. This was the special event for benefit of Cuyahoga's Health Careers Scholarship Fund that was held at the Sheraton Cleveland and at which the May Company of Cleveland presented a style show of designer fashions. (Did you know that the fragrant lilac was mentioned as early as the 16th century? John Gerard, an English missionary, in 1597 described the "blue and white pipe privets." Thanks to Mary Lou Kohn of Cleveland for this bit of interesting information.

The April meeting of the **Hamilton County** auxiliary featured the Cincinnati Civic Ballet which performed for the group at the Netherland-Hilton Hotel. Mrs. Maurice Marsh, chairman of the day, introduced David McLear, artistic director of the ballet, who presented his group in numbers by Peter Tschaikovsky, Bernard Rogers, Cesare Pugni and Franz Josef Haydn. Luncheon followed the program. Hospitality chairman for the day included: Mrs. John L. Thinnes, Jr., and Mrs. J. Philip Fox. They were assisted by Mrs. Luis L. Gonzales and Mrs. Arthur T. Evans.

The Religious Angle

Lucas County's March meeting was its annual "Invitational Dessert" and General Meeting. Guest speaker was Dr. J. Herbert Manton, clinical director of the American Foundation of Religion and Psychiatry in New York. His topic was "How Religion and Psychiatry Work Together." The speaker had served as staff psychiatrist and later director of the Toledo Mental Hygiene Clinic before he left in 1967 to join the Foundation in New York. The auxiliary's annual bridge luncheon was held on April 9 for the benefit of AMA-ERF. It is interesting to note that this group of women, in addition to everything else in which they are involved, sponsor nine special study groups which are now meeting. They include Continuing French, Conversational French, Beauty Through Ballet, Tennis, Badminton, Advanced and Beginner Bridge, Conversational Spanish, Gourmet Group and Antique and Art Glass.

Scioto County members gathered at the home of Mrs. George Obrist in March for a luncheon and International Health "special." A tremendous number of drug samples and other needed items for World Medical Relief that had been collected by members were brought to this meeting and then "packaged" for shipment. It was a busy afternoon and a rewarding afternoon, says Scioto's president, Mrs. Clyde Hurst.

The February meeting of this group was a Valentine luncheon at Harold's Restaurant at which Paul Doyle, well-known landscaper, spoke fittingly on "Roses." Election of officers for 1968-69 also was held. The forthcoming official family includes: Mrs. William Daehler, president; Mrs. Richard Villarreal, president-elect; Mrs. Alden Oakes, vice-president; Mrs. Jack MacDonald, secretary; Mrs. Donald Appleton, treasurer; Mrs. James F. Scott, historian. Installation will take place at the group's traditional May Breakfast at the home of Mrs. H. M. Keil.

AMA "Special"

Auxiliary members are cordially invited by our parent organization to attend a most important session in San Francisco on Sunday night, June 16, at the California Masonic Memorial Temple. In the light of all the discussion and feeling aroused over recent heart transplants, this program promises to be of unparalleled importance. "The Limits of Medical Responsibility in the Prolongation of Life" will be moderated by the Rev. Paul B. McCleave, LL. D., director of the Department of Medicine and Religion of the AMA. Serving as panelists on this provocative issue will be: Vincent Collins, M. D., Department of Anesthesia, Cook County Hospital; the Rev. Jack Provonsha, Ph. D., Professor of Christian Ethics, Loma Linda University; Francis Moore, M. D., chief of surgery, Peter Bent Brigham Hospital; and Howard P. Lewis, M. D., Chief of Internal Medicine, Oregon University Medical School. Specific topics of discussion will include "Human Experimentation," "Machine Medicine," and "The Artificial Heart."

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Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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241 Hudson

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street. Suite 500, Columbus. Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

GENERAL PRACTITIONER OR INTERNIST Available immediately, ready practice for G. P. or Internist who would consider small amount of family type general practice. Group consists of two G. P.'s and Surgeon, in new medical building with complete laboratory service and close to local, open staff, hospital. Salary first year leading to partnership, no investment. Suburban community well located in the Cleveland, Mansfield, Akron triangle, excellent school system. Housing available. Reply Box 422, c/o Ohio State Medical Journal.

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ANESTHESIOLOGIST: Part-time, solo, fee for service; board qualified; any area considered; also interested in inhalation therapy consultation; therapeutic and diagnostic blocks; only interesting offers answered. Reply Box 535, c/o Ohio State Medical Journal.

WANTED: One or two medical doctors interested in being family physicians with practice limited to internal medicine and pediatrics in highly progressive suburban community. Excellent hospital facilities, no night house calls, daytime house calls less than one per week, equal time off. Community offers excellent school system and many recreational facilities for children and adults. Great financial opportunity, fees for service at onset, partnership later. If interested, call collect, area code 216-499-6211. William T. Krichbaum, M. D., 434 North Main Street, North Canton, Ohio 44720.

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(Continued from Previous Page)

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Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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(chlordiazepoxide)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

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The OHIO STATE MEDICAL Journal

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21 JUN 1968

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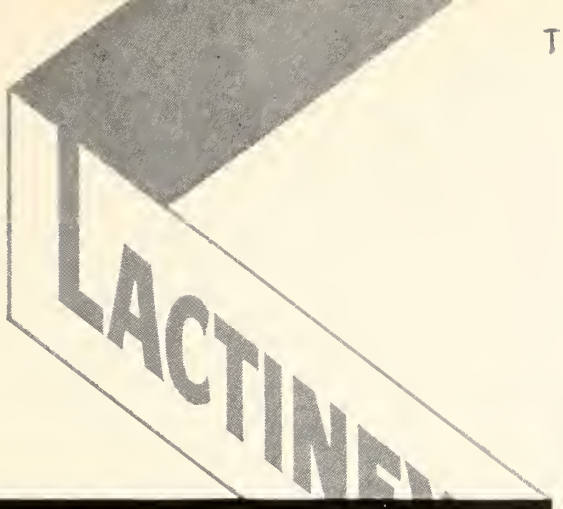
The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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VOL. 64 JUNE, 1968 No. 6

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Address All Correspondence:
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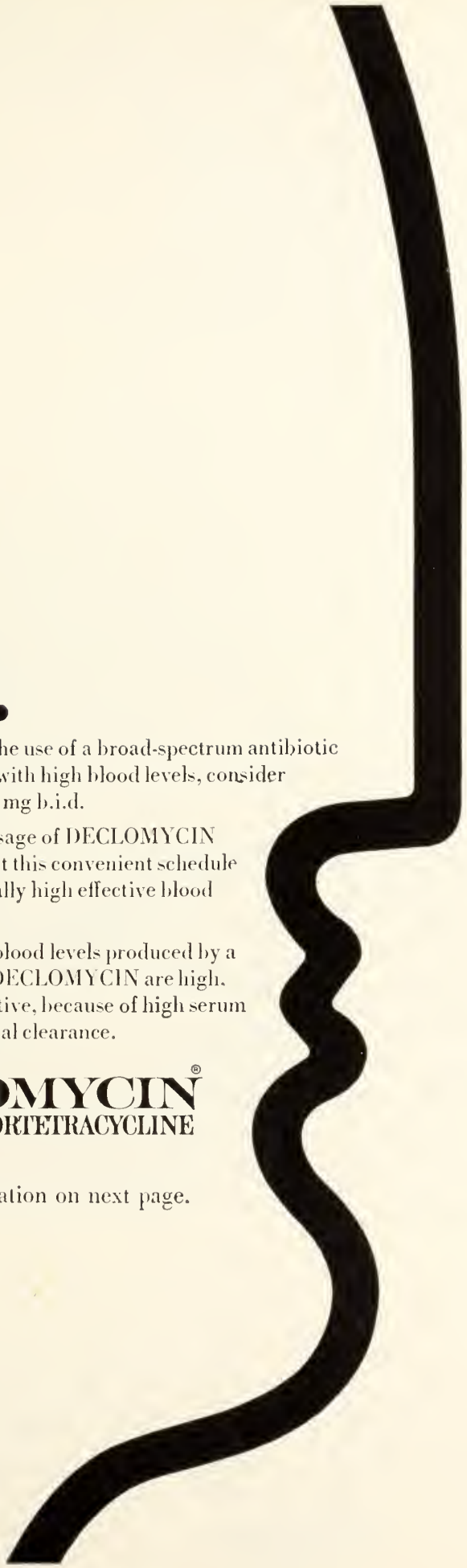
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Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg every 6 hours for a minimum of 4 doses or 300 mg every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg every 6 hours or 300 mg every 12 hours until a cure is effected.

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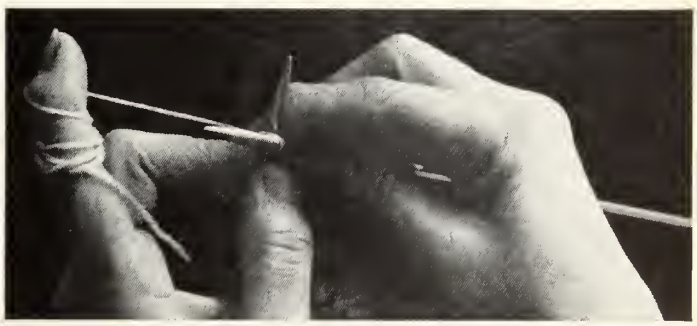
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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 4-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-A

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New Practice Management Guide Announced by the AAGP

A 105-page manual designed to provide the general or family physician with professional help in handling business aspects of medical practice and community and professional relationships involved has been developed by the American Academy of General Practice.

The manual "Organization and Management of Family Practice" attempts to fill a need for expert advice in an area largely neglected by medical schools and professional organizations, states Dr. Raymond M. Kahn, Dayton, chairman of the AAGP Committee on Medical Economics which guided development of the manual. It is aimed at the graduate who wishes to avoid costly errors in establishing his first practice, and the practicing physician who wants to evaluate the efficiency of his present office procedures, Dr. Kahn says.

Members of the Society of Professional Business Consultants, a national association of business management consultants, were retained to study the unique problems of running a medical practice and to develop the 50-page middle section on Practice Organization and Management.

The next to last chapter deals with the professional associations (hospitals, social welfare agencies, blood banks, nursing homes, pharmacies, etc.) and business contacts (management consultants, attorneys, banks, credit agencies, etc.) The final chapter discusses the services and programs available to family doctors through membership in such professional associations as the American Medical Association, American Academy of General Practice, and local medical societies.

The manual is being made available to all Academy members. It also will be made available free of charge on request to medical students, interns, residents, and medical school and hospital libraries. Others interested in obtaining a copy may do so at $1 per copy from the American Academy of General Practice, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Air Pollution Program Sponsored In Denver by the AMA

The Ninth American Medical Association Air Pollution Medical Research Conference is scheduled to be held July 22-24 at the Denver-Hilton Hotel, Denver, Colorado. Registration opens at 6:00 P.M. on Sunday, July 21. Registration fee is $12.00.

Cooperating organizations are the American College of Chest Physicians, American Thoracic Society, Colorado Medical Society, Colorado State Department of Public Health, Denver Medical Society, and the U. S. Public Health Service.

Additional information may be obtained from the Department of Environmental Health of the AMA.

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METHYCLOTHIAZIDE

Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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TM-TRADEMARK

Title XIX, The State Medical Journal and The Pharmaceutical Manufacturer

By ROBERT S. WARNER, M. D.*

The concept of Title XIX and implications of this program, together with current governmental investigations and hearings, can have a marked effect on the state journal and its readers as well as the pharmaceutical manufacturer. Title XVIII, or Medicare has received far greater recognition than Medicaid, or Title XIX, which was tacked onto this medical care bill. Title XIX is known as the "big sleeper" and, with current trends, it is becoming evident that the tail will soon be wagging the dog.

As you know, Medicaid legislation called for the states to consolidate health care benefit programs—including old age assistance, aid to the blind, aid to the permanently and totally disabled, aid to families with dependent children and medical assistance to the aged as well as other welfare programs—into a single comprehensive program of medical services. It also directed the states to include medical assistance for otherwise healthy persons who could not afford health care expenses.

A deadline for the development of this comprehensive program through state legislation is set for January, 1970, if federal payments are to continue. At the time of this presentation, 26 states and three federal jurisdictions—Puerto Rico, Virgin Islands and most recently Guam—have developed programs conforming with Title XIX legislation. Twenty-eight of these programs were in operation prior to the close of the fiscal year ending June 30, 1967. The estimated cost for these programs was $1.9 billion and the spending for prescription drugs has been estimated to be 9 per cent of the total or slightly more than $179 million. Medicare covered close to $3 billion in health care payments during the fiscal year ending on June 30, yet despite the fact 25 of the nations, 54 states and territories are NOT participating in Title XIX or Medicaid as yet; this program utilized almost two billion dollars in funds. Assuming that by 1970, all 54 states and territories will be eligible for federal funds with Medicaid programs, the annual cost for health services will be at the level of six billion dollars per year, far surpassing its twin Medicare.

Enormous Coverage

It is estimated that 35 million persons under age 65 will soon be covered by Medicaid programs, whereas the Medicare program will benefit 17 million people over age 65. Estimates of drug costs for these groups will total—$1.4 billion; $600 million for the Title XIX program and $800 million for Medicare, Office of Economic Opportunity antipoverty programs, and other federal supported programs.

Drug prescribing in some states is limited by a formulary system, however, the established formularies in only seven states vary considerably as to the number of drugs available—from 97 to 1,368—to all drugs listed in the Physicians' Desk Reference. In some of these states, general prescribing is compulsory, while no restrictions on the type of prescribing is enforced in others. Most of the other states and jurisdictions operating Medicaid programs emphasize "The choice of the physician in the use of drugs in his prerogative." This is as it should be. Limitations on number of refills of prescriptions and total dollar amount of prescription drugs ordered each month for a patient make some of the programs restrictive as far as patient benefits are concerned. Title XIX drug costs are probably going to represent a greater percentage of this program expenditure—a rise from 9 to 11 - 12 per cent is predicted.

Two bills under consideration, if passed, might well place a national restriction on the physician's use of drugs. The Montoya Bill is designed to all prescription drugs to Part B—The Non-Hospitalized Patient of Medicare—with reimbursement based on the price of generic drugs in a National formulary. The Long Bill provides that drugs prescribed under federal medical programs be paid for according to a price of acceptable Generic drug in a national formulary, but will not require generic prescribing per se. Development of a national generic formulary where price is the limitation certainly is not in the best interest of the patient and takes away the prerogative of the physician as to choice of drug therapy in a certain group of patients.

The principle of *Caveat Emptor*—let the buyer beware—cannot be exercised by the patient obtaining prescription drugs. Therefore, it is the responsibility of the physician to see that the patient does not "buy at his own risk." Only by freedom in the choice of drugs, whether they be generic or trade name, for patient care can the doctor protect the buyer/patient.

47 Million Patients

The Legislators have promised a standard of medical care equal to that of private patients. It has already been recognized that the federal supported programs have met with unforeseen limitations in limited

*Dr. Warner is Director of Professional Marketing Services, Wyeth Laboratories, prescription drug manufacturing firm of Philadelphia, Pa. This article is part of the text of an address given before the biennial Conference of State Medical Journal Editors and Business Managers, Chicago, September 19, 1967.

Is it depression?
He says "It's my stomach..."



...but his other symptoms:
functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

when the diagnosis is depression

ELAVIL® HCl
AMITRIPTYLINE HCl

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

Before prescribing or administering, read product circular with package or available on request.

MERCK SHARP & DOHME Division of Merck & Co Inc West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

hospital facilities and a shortage of both medical and paramedical personnel. Now, with the threat of a National Formulary looming on the horizon, further limitation on the practice of medicine could affect your readers, the practicing physician. We, as physicians, must live with Medicare and Medicaid. After all, by 1970 we will be taking care of 47 million patients covered by these and other federal programs.

Pending legislation designed to expand these programs could make the Federal medical programs more costly to you and your readers as taxpayers and less desirable for the practice of good medicine. Before we are sold on these proposed legislative changes, we, too, might well listen to the admonishment, *Caveat Emptor!*

Ever Tighter Regulations

Passage of the Kefauver-Harris Act in 1962 resulted in new controls and regulations for the pharmaceutical industry. In the past two years, the enforcement and interpretation of these regulations by the Food and Drug Administration have been directed at the pharmaceutical manufacturer. These have been manifested by Dear Doctor Letters, Citations, and Seizure of drugs. These actions by the FDA have not been, for the most part, the result of substandard drugs being marketed, but rather violations based on labeling, as reflected in advertising and promotional claims which is interpreted as an extension of official labeling.

Likewise, greater restrictions have been placed on the investigator who has carried on clinical evaluations of new drugs. These activities by the FDA are now industry directed, but the implications of this type of regulation and recent developments with regard to medical communications and the practice of medicine should concern all physicians.

Let's see what has happened to medical communication or advertising from the standpoint of the pharmaceutical industry. All promotional materials, including journal advertising must adhere to the approved conditions for use and dosage recommendations. As reflected to the FDA approved "Directions for Use" or the "Package Insert," journal advertising must contain a precise or brief disclosure including precautions, contraindications, side effects, and limitations of use, while other printed and promotional materials must contain what is known as full disclosure—all pertinent material as printed in the official Direction Circular.

If a reference to a clinical study is cited in one of the printed advertising pieces, this reference must conform to the drug dosage, indications and use given in the official direction circular. Likewise, the reference or references must cite the undesirable qualities as well as the beneficial aspects of a therapeutic regimen. If these criteria are not met, the drug manufacturer advertising his product is in violation. It has been implied that an advertising agency involved with such an ad and a journal editor accepting such advertising also might well be in violation.

Recently, an editorial battle between Dr. Walter Modell, professor of pharmacology, Cornell University Medical College and the medical director, Bureau of Medicine, the FDA, Dr. Herbert Ley has attracted considerable attention. The editor and publisher of a well known textbook of pharmacology, after confrontation with the officials of the FDA sent out an erratum notice referring to a table on drug dosage.

This is the only instance of a disclaimer being required in a medical publication but the FDA has supplied suggested wording for a disclaiming statement. I quote, "The drug dosage recommended herein represents the author's opinion of appropriate dosages based on his clinical experience. The reader is referred to the package insert for significant details regarding usual dosage, side effects, contraindications and warnings." Are you as editors prepared to request authors to add this disclaimer to all clinical report involving drug use not in complete conformity with the package insert?

More important, it has been stated by Dr. Ley that "Any physician may, on his own responsibility, administer a drug for an unapproved use, or he may increase or decrease the dose in caring for a patient." However, Dr. Ley further states that the physician generally is aware that in any legal case which may ensue, the issue of his liability may turn on whether he followed the Drug Labeling (Package Insert) approved by the manufacturer and the FDA."

Central Dictation Looms

With the possibility of a National Formulary limiting the prescribing of drugs under Federal supported programs and the FDA—suggested compendium of drug information containing approved package insert information, there is a definite threat to the practice of medicine. Such an official compendium of government approved drug dosage and uses could well represent the legal standard of therapeutic care.

Until recently, only the pharmaceutical manufacturer has been involved with the FDA regulations as related to advertising. True, some advertising has been canceled in your journals as a result of citations and seizure. The new proposed advertising regulations (the legality of these regulations have been seriously questioned by several groups) could do much to curtail journal advertising.

Certainly any further regulation and limitation of journal advertising can have definite implications for you and your editorial programs. Now, with the possibility of further regulations being applied to the practice of medicine, the situation is more grave. A warning written by Dr. Joseph Cooper, professor of government, Howard University, is most timely: "From the standpoint of the practicing physician, it has never been more timely to get into the debate, for upon its outcome may depend the extent to which

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new Gerber® Toddler Meals assure nutrition.

Developed especially for toddlers

These new products were specifically developed to meet the needs of children graduating from baby foods. Combining convenience, texture and grown-up taste appeal with sound nutrition, Gerber research has created Toddler Meals in ten tasty varieties.

Superior nutrient/ calorie ratios

The nutritional characteristics of these casserole meals are excellent. High in critical nutrients, Gerber Toddler Meals are the answer to the problem of empty calories.

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Now when mothers ask your advice, consider this new step from baby foods to adult foods for assured nutrition.

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professional medical practices are to be centrally dictated, covering availability and choice of drugs and determination of dosage."

Since this social program, Medicaid, is becoming more complex, it seems that this program provides the front for regulation and limitation of certain phases of medical practice. Legislative programs and governmental agencies will certainly contribute to regulate federal supported health care programs. As editors, you have both the opportunity and responsibility to inform and warn your readers of the potential hazards involved with Medicaid related legislation and regulations. You can urge readers "To get into the debate," especially at the Congressional District level.

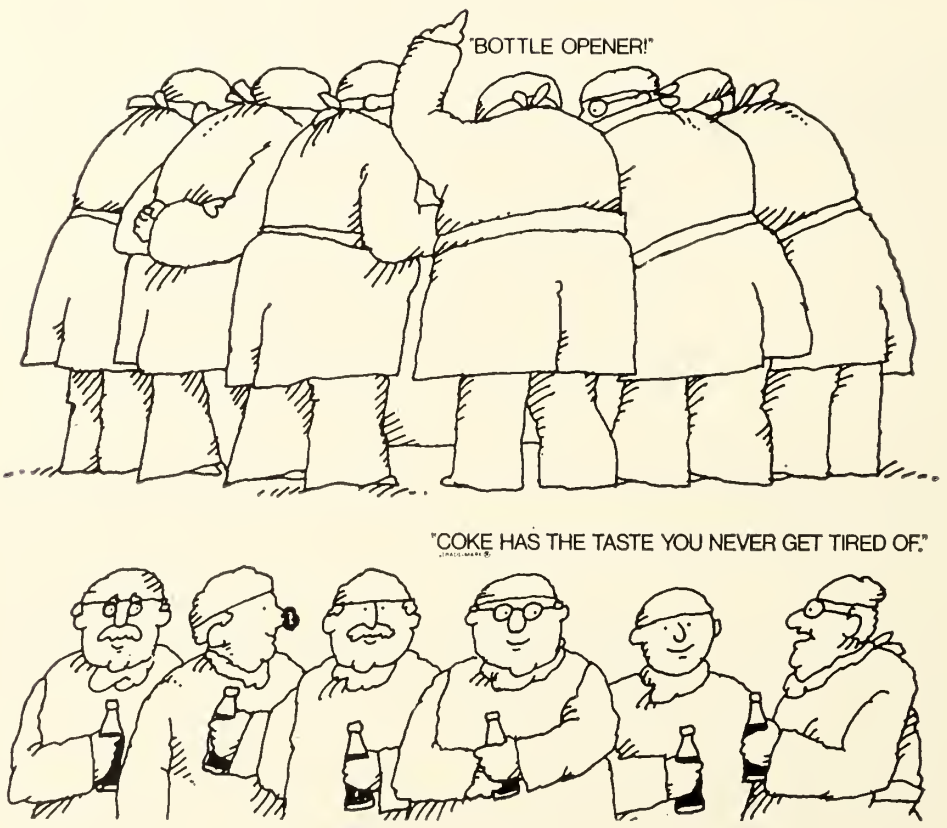
The physician should carry out his own campaign in informing both his patients and community to become aware of the threats, both economic and medical, that might be induced by existing and proposed regulations. What better means is there to communicate with physicians at the local level than through the State Medical Journal. As a physician, I recognize the state journal as a most effective way to get my company's product story to the practicing physician in your states.

Since you have this excellent communicating tool at your disposal and an involvement both as a physician and editor, I urge you to continue to warn and inform your readers about the developments within Medicaid, the progress of legislative proposals that will effect this and other federal programs, and attempts to further regulate medical practice. You as influential medical editors, your readers, the practicing physician, and we of the pharmaceutical industry must cooperate in maintaining the freedom of medical practice and attendant drug therapy. Let's not be sold on any new programs without first heeding the warning of Dr. Cooper and the admonition—*Caveat Emptor!*

Memorial Fund Is Established For Steubenville Doctor

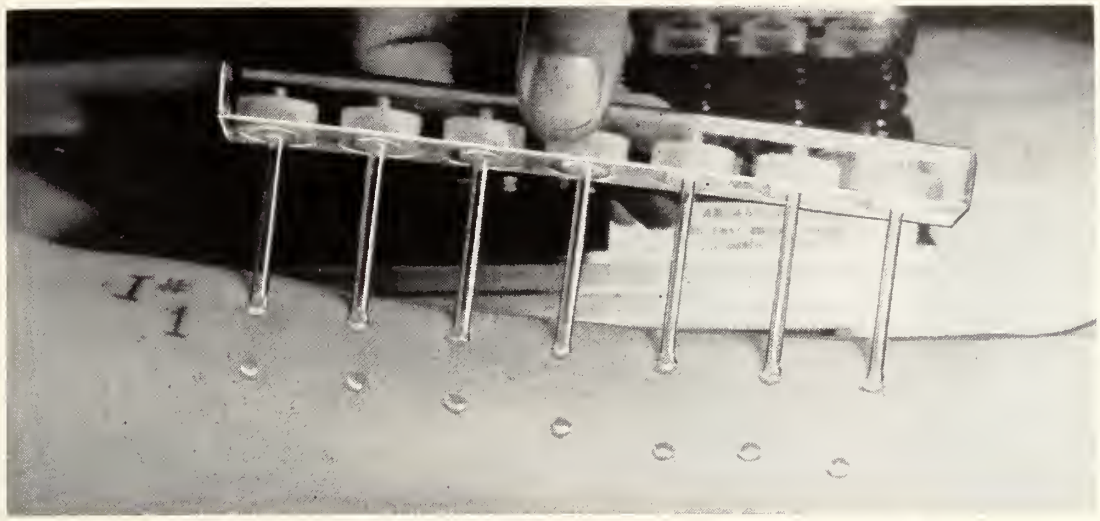
Plans were announced recently for the formation of a fund to perpetuate the memory of the late Dr. Dominic A. Macedonia, Steubenville physician, civic, church, and fraternal leader, and a member of the State Medical Board of Ohio. The memorial would be established somewhere in the Steubenville community.

Dr. Sanford Press, Steubenville physician and leader in medical organization work, has been named memorial fund chairman. Persons interested in making donations should make them payable to the Dr. D. A. Macedonia Memorial Fund, First National Bank and Trust Company, Steubenville.



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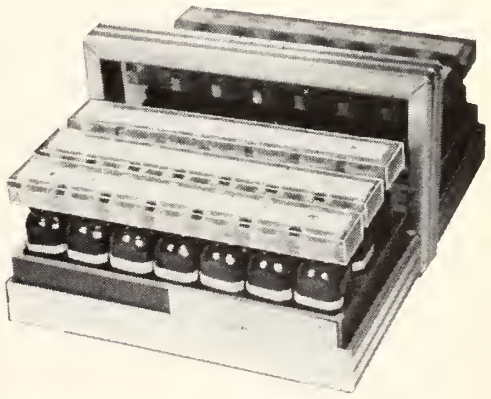
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This easy three-step allergy test kit contains 42 Allergens, clinically selected. The new testing technique allows you or your nurse to apply 7 different drops of potent allergens to the skin at one time. It's economical, fast . . . allowing you to manage allergy diagnosis with minimum time and cost.



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The physician's prescription of therapeutic antigens for the individual patient are carefully compounded in our laboratories by following the clinical diagnostic indications of skin test and history reports submitted.

The prescription treatment sets are sent to you in four vials of graduated dilutions to support a conservative dosage schedule and to permit a dosage adjustment if indicated by your patient's sensitivity.



STOCK TREATMENT SETS AVAILABLE

When clinical diagnosis indicates a clear seasonal pattern of sensitivity you may desire a combination of the most prevalent antigens occurring in that season. You may choose from these stock treatment sets; Ragweed Mix, Grass Mix, Mixed Mold Treatment, Dust Treatment, Animal Dander (dog, cat or horse). Stinging Insect Mix.

SINGLE VIAL Rx

Each vial is made to the individual doctor's prescription of antigens, creating a constant control of therapy, reflecting patient reaction and tolerance. This enables the doctor to adjust dilution and add or delete antigens with each vial as indicated by patient's reaction. ALO maintains a permanent, fast referrence patient record of each prescription.

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AMA San Francisco Convention . . .

Vast Panorama of Current Developments in Medicine and Surgery Will Dominate West Coast Meeting, June 16-20

THE FORTHCOMING 117th Annual Convention in San Francisco June 16-20 will present a vast panorama of all that is current in every area of medicine and will beckon more than 60,000 persons, all of whom will be drawn closer to the heartbeat of medicine and its eternal promise just by being a part of it.

At least 16,000 of them will be physicians taking advantage of a remarkable educational opportunity which will enable them collectively and individually to learn and implement proven methods and techniques destined to further improve the quality of medical care not only for Americans, but for people everywhere.

Indicative of the quality, scope, and thoroughness of the Scientific Program in which they will participate is the fact that more than 2,000 men and women of eminence, of whom the overwhelming majority are physicians, will be presenting it.

Under the direction of the AMA's Council on Scientific Assembly, they have amassed the most timely and productive program possible. Its all-inclusiveness guarantees that it will contain subject matter beneficial to every physician, no matter what his area of medical practice or interest.

Among the highlights of the Scientific Program will be discussions, symposia, lectures, panels, exhibits, research reports, color television, and medical motion pictures.

There will be more than 253 Scientific Exhibits, a phase of the program now in its 68th year and brought into existence in 1898 when the convention was held in Columbus, Ohio.

At San Francisco, physicians also will have the opportunity to view 42 current medical motion pictures. Historically, the presentation of such educational films has been an integral part of the Scientific Program, although it was excluded from the program from 1928 until the Annual Convention in 1946, when postgraduate films again became a regular part of the program.

TV Highlights

Medical television made its debut in 1948 at the Clinical Convention in St. Louis, where it was presented in black and white through the sponsorship of E. R. Squibb & Sons. A year later color television was introduced and has been continued without interruption through the cooperation of Smith, Kline and French Laboratories.

Established in 1915 to supervise and coordinate the activities of the various Sections of the Scientific Assembly, the Council on Scientific Assembly has been persistent in its search to arrange the most effective Postgraduate Medical Education Program possible each year. Prior to 1915 each Section had arranged its own program separately.

The four general sessions are as follows:

Automobile Accidents, with participation by Sections on Orthopedic Surgery, General Surgery, Pediatrics, Physical Medicine, and Preventive Medicine, as well as the AMA Committee on Medical Aspects of Automotive Safety.

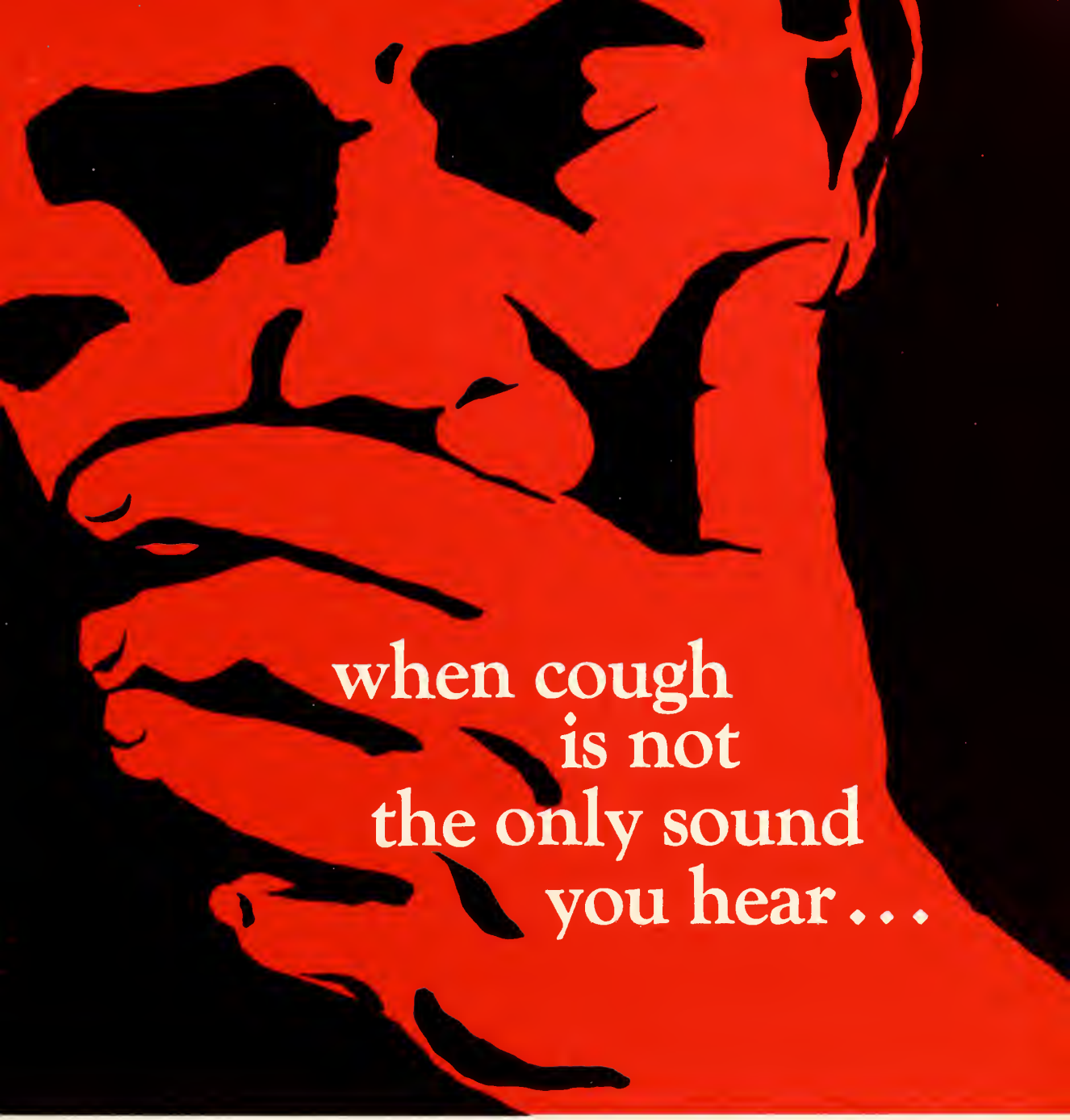
Health Care Planning, with participation by Sections on Preventive Medicine, Diseases of the Chest, General Practice, General Surgery, Internal Medicine, and Military Medicine.

Management of Infectious Diseases, with participation by Sections on Experimental Medicine and Therapeutics, Allergy, Diseases of the Chest, General Surgery, Pediatrics, and Preventive Medicine.

Treatment of Advanced Malignant Disease, with participation by Sections on General Surgery, Gastronenterology, General Practice, Internal Medicine, Nervous and Mental Diseases, Pathology and Physiology, Colon and Rectal Surgery (formerly Proctology), and Radiology.

Regular scientific programs also will be presented by each of the 22 Scientific Sections, plus a program by the Section on Miscellaneous Topics.

The entire scientific program appeared in the May 6 issue of the *Journal of the American Medical Association.*



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

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Health and Medical Care Figures Released by HEW Office

Some interesting figures on national health expenditures involving both public and private funds are reflected in two articles which appeared in the April issue of the *Social Security Bulletin,* official monthly publication of the Social Security Administration. Public outlays in the form of Medicare benefits started in July 1966. The following information from the articles was prepared and released by the Social Security Administration.

One report stated that the $1.2 billion in benefits paid under Medicare during the second half of 1966 was a major factor in boosting public expenditures for health as a proportion of all health expenditures.

The nation spent $45.4 billion for its health and medical care during the year. The public outlays amounted to 28 per cent of this total, up from 25 per cent in the 1965 total. The increase in public expenditures in 1966 was four and one-half times the increase in private expenditures.

In 1966, benefit payments under group health policies of private insurers increased by six per cent, while contributions rose seven per cent. The annual growth rate of employee-benefit plans ranged from 10 to 15 per cent over the previous 10 years.

The total for all benefits paid under the private pension, health and welfare plans reached $14.4 billion, of which $7.4 billion were health benefits. Contributions by employers and employees totalled $20.8 billion, of which $8 billion were for health benefits.

The increase in national health expenditures since 1950 has been 57 per cent. In terms of 1966 dollars, the per capita national health expenditure in 1950 was $146.94. By 1966 it had reached $230.69.

Hospital care in 1966 was the largest single item of expenditure, representing more than one-third of total outlays. Physicians' services were the next largest (21 per cent of the total), followed by outlays for drugs and drug sundries and for dentists' services.

With the introduction of Medicare, employers made adjustments to take the new public program into account for their employees (and retired workers) aged 65 and over. It is estimated that, before Medicare went into effect, more than five million persons aged 65 and over had group hospital coverage. It is now estimated that about 3.7 million aged persons are still enrolled in group hospital plans (either on the job or as retired persons) that are complementary to Medicare.

Limited copies of the *Social Security Bulletin* are available from the Office of Research and Statistics, Social Security Administration, Room 5628, HEW South Building, Washington, D. C. 20201. The *Bulletin* is for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price, 25 cents a copy, $2.75 a year.

AMA Establishes Approval Program For Laboratory Assistants

The American Medical Association's Council on Medical Education has established, in cooperation with the American Society of Clinical Pathologists, an approval program for certified laboratory assistants.

It is the ninth health occupation for which the AMA now maintains approval programs to assure that training standards acceptable to the medical profession are being met.

Before the AMA established the approval program last December, schools for certified laboratory assistants were approved only by the American Society of Clinical Pathologists.

The original certification program, aimed at providing standardized training and national certification under medical auspices, was initiated in 1963 by the ASCP and the American Society of Medical Technologists.

Upon completing an accredited 12-month course of hospital or laboratory school training and passing an examination, graduates are designated as certified laboratory assistants. To meet the increased demands for laboratory service, the AMA estimated that 100,000 certified laboratory assistants will be needed by 1975.

The current list of AMA-approved schools for laboratory assistants, as well as lists of other AMA-approved or accredited schools—cytotechnology, inhalation therapy technician, medical record librarian, medical record technician, medical technology, occupational therapy, physical therapy and x-ray technology—may be obtained by writing the AMA's Department of Allied Medical Professions and Services, 535 N. Dearborn Street, Chicago, Illinois 60610.

A six-page pamphlet, "A Career for You as a Certified Laboratory Assistant," may be obtained by writing the Secretary, Board of Certified Laboratory Assistants, 445 N. Lake Shore Drive, Chicago, Illinois 60611.

Cleveland Clinic Is Host To Former Fellows

Former fellows—doctors who served their residencies at The Cleveland Clinic Foundation—held a two-day meeting April 26 and 27.

Occasion was the ninth Former Fellows Reunion at the Cleveland Clinic. Such reunions are held every three years for former residents who underwent specialized training at the Clinic following their internships.

The Thomas E. Jones Memorial Lecture was presented by Dr. Richard Kennedy Gilchrist of Chicago. He dicussed "Lymphatic Spread of Carcinoma of the Colon and Rectum." The lecture is a tribute to Dr. Jones, former Clinic chief of surgery who died in 1949.

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AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

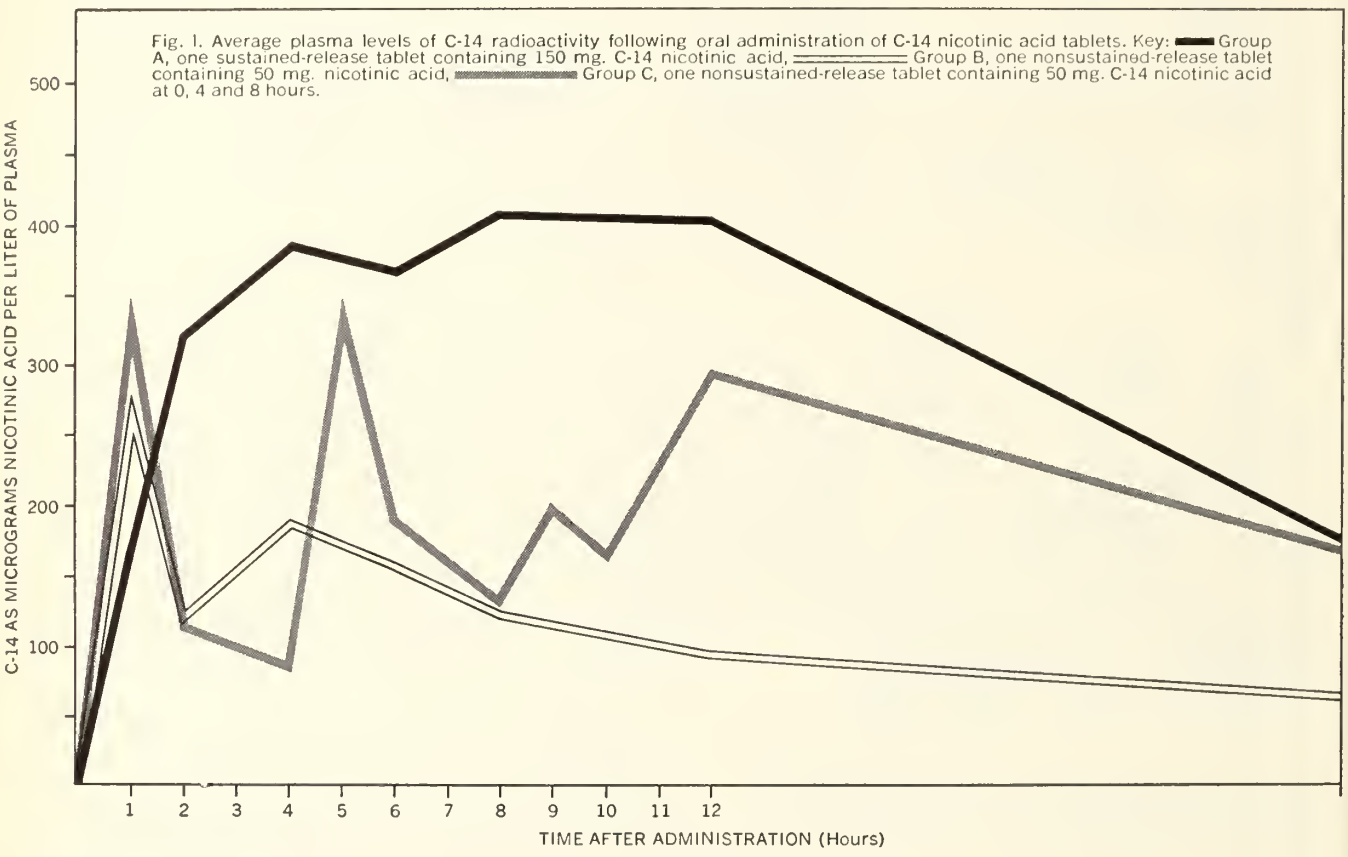
Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Amb suppresses appetite and helps offset em tional reactions to dieting. **Contraindic tions:** Hypersensitivity to barbiturates sympathomimetics; patients with advanc renal or hepatic disease. **Precautions:** Administer with ca tion in the presence of cardiovascular disease or hypertensio **Side Effects:** Nervousness or excitement occasionally note but usually infrequent at recommended dosages. Slight drow iness has been reported rarely. See package insert for furth details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBIN

Sustained circulatory, respirator
and cerebral stimulation for th

Fig. 1. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

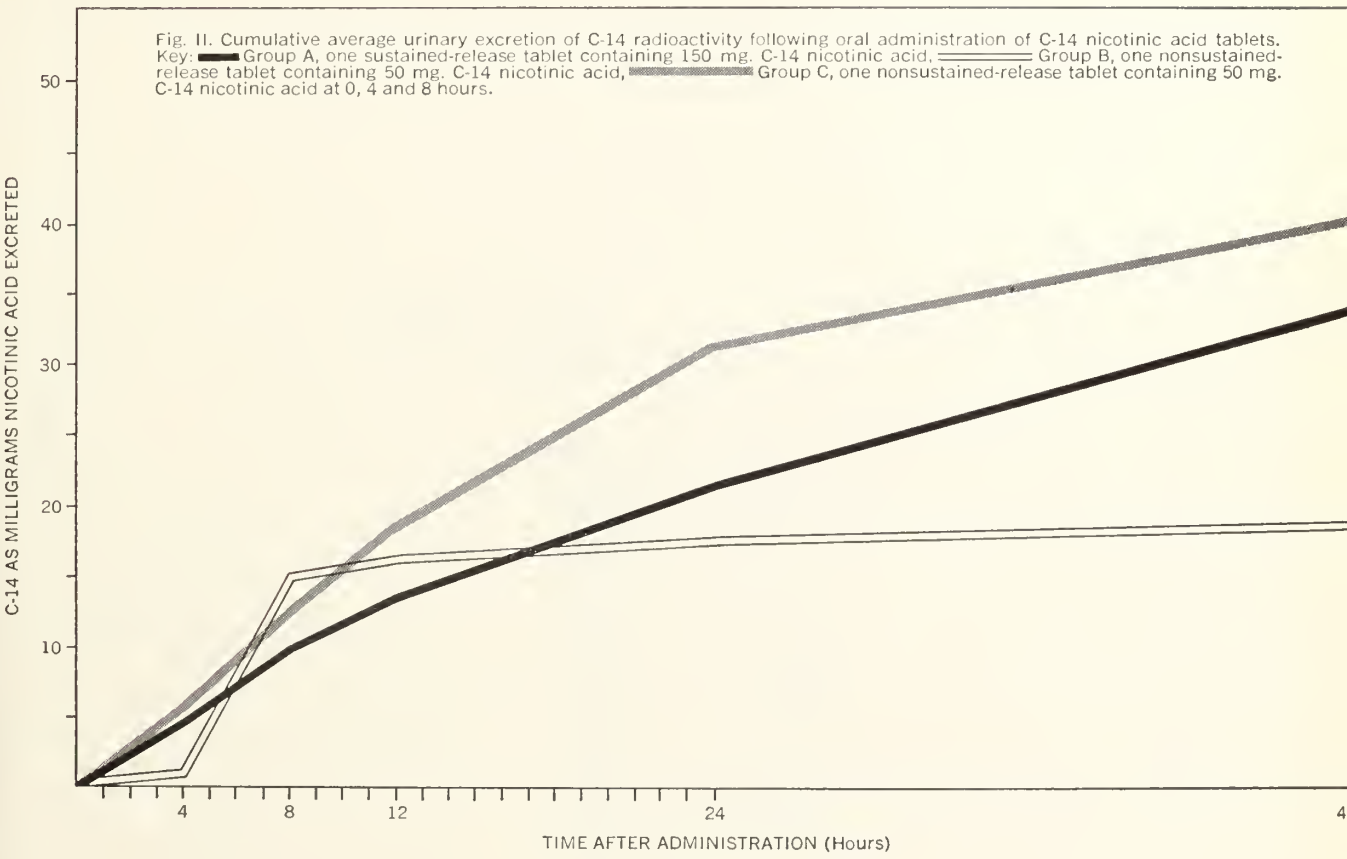
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
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Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

An anorectic will help her lose weight–
but can she keep it off?
You need more than a pill
(even ours) to do that!



That's why Abbott offers you a pill plus a program.

ABBOTT

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444



Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during April. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Allen
Lily W. Cheng, Lima
Todd C. Stallkamp, Delphos
Francisco Vidal, Lima

Columbiana
Salvatore C. Apicella, Salem

Crawford
Jose R. Ramirez, Bucyrus

Cuyahoga
Anastacio A. Belleza, Cleveland
Lauro B. deVera, Lorain
Carl F. Doershuk, Cleveland
Ricardo C. Gatchalian, Cleveland
Samuel J. Horwitz, Cleveland
Richard C. Hutchinson, Cleveland
Kenneth P. Johnson, Cleveland
Rudolfo M. Lontoc, Cleveland
Martin C. McHenry, Cleveland
Kazimir J. Odrcic, Cleveland
Kathryn L. Popowniak, Cleveland
Lino S. Ramos, Cleveland
Mehdi Razavi, Cleveland
Ernest J. Simak, Cleveland
Robert C. Tarazi, Cleveland
Frank M. Tilton, Cleveland
Tacettin M. Uray, Cleveland
John F. Viljoen, Cleveland

Franklin
Walter W. Hamilton, Columbus
Rosemary W. McLaughlin, Columbus
Robert L. Wick, Jr., Columbus
Emira D. Zubchevich, Columbus

Gallia
Donald E. O'Rourke, Gallipolis
Arnold J. Sattler, Gallipolis

Lucas
Peter J. Cardillo, Toledo
Jon Leo Konzen, Toledo
Nasr A. Mansour, Toledo

Mahoning
Fernando A. Carbonell, Youngstown

Montgomery
Sam O. Atkins, New York (Military Service)
Enrique Leon, Oklahoma (Military Service)

Sandusky
Allen Schaengold, Fremont

Stark
Ben A. Finkelstein, Canton
Earl F. Limbach, Massillon
Luis M. Palomar, Canton

Summit
Nicholas D. Wing, Akron

Trumbull
Orhan K. Basaran, Warren
Servillano Y. Yumang, Niles

IRS Rules No Depreciation on Radium for Tax Purposes

The April 28 issue of the Internal Revenue Bulletin published by the Treasury Department contained the following notation with reference to Section 167 of the Internal Revenue Code: 26 CFR 1.167(a)-1: Depreciation in general
Rev. Rul. 68-192

The taxpayer acquired radium and used it in his trade or business as a therapeutic agent. The life of radium has been scientifically estimated to be indeterminate. No appreciable depreciation results from its continued use as a therapeautic agent; therefore, it does not have a determinable useful life to the taxpayer in his trade or business.

Accordingly the cost of the radium must be capitalized by the taxpayer, but no deduction is allowable for depreciation. The return of the capital cost will be realized upon the sale of other disposition of the radium.

O.D. 837, C.B. 4, 178 (1921) is superseded since the position therein is restated under the current statutes and regulations in this Revenue Ruling.



Vacation trip....

Motion sickness?



This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.

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phosphorated carbohydrate solution
emesis control

Easy on the Budget...
Easy on the Mother

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For Iron Deficiency Anemia

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The Historian's Notebook

Medicine in Fairfield County, Ohio, 1800-1850

By CHESTER P. SWETT, M.D., Lancaster, Ohio

PART II

(Continued from May Issue)

Until 1824, there had been no concrete laws concerning the regulation of the practice of medicine. In that year the General Assembly of Ohio passed an Act calculated to remedy that condition. This Act, passed on February 24, 1824, provided for the State to be divided into 20 medical districts. The Act was repealed in 1833. During this period the Medical District Societies functioned with variable success. They were authorized to examine and grant licenses to suitable candidates, giving them the right to practice medicine and midwifery and surgery in the district and also to prosecute illegal practitioners within the confines of its jurisdiction. The Societies were also empowered to set standards for medical practice and for professional conduct.

The Thirteenth District Medical Society included Fairfield, Hocking and Perry Counties. A meeting convened in Lancaster on March 24, 1824. The physicians who were present were Drs. Silas Allen, Robert McNeill, James White, Pardee, Gregg, Wait, and Harris. The gentlemen admitted to an association were Drs. Whipple, E. L. Minor, Kemper, William Talbot, James M. Shaug, John Harris, and J. H. Harris. The following officers were elected: President, Silas Allen; Vice-President, Robert McNeill; Secretary, James White; Treasurer, Ezra Clark; Censors, Robert McNeill, James White, Pardee, Harris, and Clark.

The minutes of all the meetings of the Medical Society of the Thirteenth District of Ohio have been preserved, except for the year 1831, by the efforts and interest of several people. As stated on the flyleaf of the Record Book, it "was rescued from the rubbish basket in the drugstore of Mr. E. B. White, grandson of Dr. James White, the first secretary. It was bound, the dim writing retraced, and returned to the Fairfield County Medical Society, October 12, 1906, by George Noble Kreider, A. M., M. D., of Springfield, Illinois, grandson of Dr. M. Z. Kreider, the third licentiate of the Society."

The Record Book was placed in the custody of the secretary of the Fairfield County Medical Society. Many years later, a prominent member of the society, Dr. George O. Beery, became interested in the document. He wrote an informative article concerning it, entitled "Thirteenth District Medical Society of Ohio 1824-1832." This was published in the *Ohio State Medical Journal,* August 1937, Volume 33, pages 891-895. Dr. Carl W. Brown was the secretary of the County Medical Society from 1927-1948. Sometime between 1937 and 1948, Dr. Brown, being concerned that perhaps this historical record might be misplaced or lost, turned it over to the Ohio State Museum. It remains there in the section on historical documents.

A few years ago, I recalled Dr. Beery's article and made inquiries concerning the Record Book. No one knew about it except for Dr. Charles H. Hamilton. Dr. Brown had told him of its disposition. In that manner, I was able to inspect the book and to have a copy made of the manuscript.

To revert to the minutes of the Thirteenth Medical District, it will be of some interest to note the provisions of the Bylaws of the Society. They are brief and concise. They point out the general standards of medical conduct prevalent at that time.

BYLAWS

ARTICLE 1 — This Society shall meet semi-annually, or on the last Tuesday in May and the second Tuesday in October or November holden at such places as shall be designated at each preceding meeting.

The president shall have the power to call special meetings by giving three weeks notice of such meeting antecedent thereto.

ARTICLE 2 — It shall be the duty of the Censors to examine candidates for the benefit of a license only at stated meetings, three censors at such time forming a quorum for that purpose.

ARTICLE 3 — All students making application for a license must be 21 years of age and on receiving said license, must pay into the treasury Ten Dollars, and it shall be the duty of the candidates thereafter to signify their intentions to the secretary of this Society three months previous to a stated meeting.

ARTICLE 4 — The cause of expulsion shall be penitentiary offenses, immoral conduct, malpractice and habitual intemperance, provided he shall have had at least two months notice in writing from some officer of the Society and two thirds members present concur in his expulsion.

ARTICLE 5 — It shall be the duty of every member to promote as much as in his power the diffusion of medical knowledge, correct abuses and communicate at each meet-

Now . . . a new
alternate salicylate product
rom Warren-Teed

Magan®
magnesium salicylate, W-T)

particularly offered for the management
of those chronic arthritic and rheumatic
patients with gastrointestinal intolerance
o aspirin and other salicylates

magan®

an alternate salicylate

ain relief comparable to aspirin





Magan may provide effective salicylate therapy for a substantial number of your patients who cannot tolerate other salicylates because of gastrointestinal irritation.

Magnesium salicylate is recognized as a safe and effective alternate to aspirin. A controlled clinical study showed Magan to be not significantly different from aspirin as an analgesic in the treatment of arthritic patients.[1]

Reports from a private practice experience study indicate that Magan was tolerated by a high percentage of patients judged by their physicians to be unable to take aspirin or other salicylates due to gastrointestinal intolerance.[2]

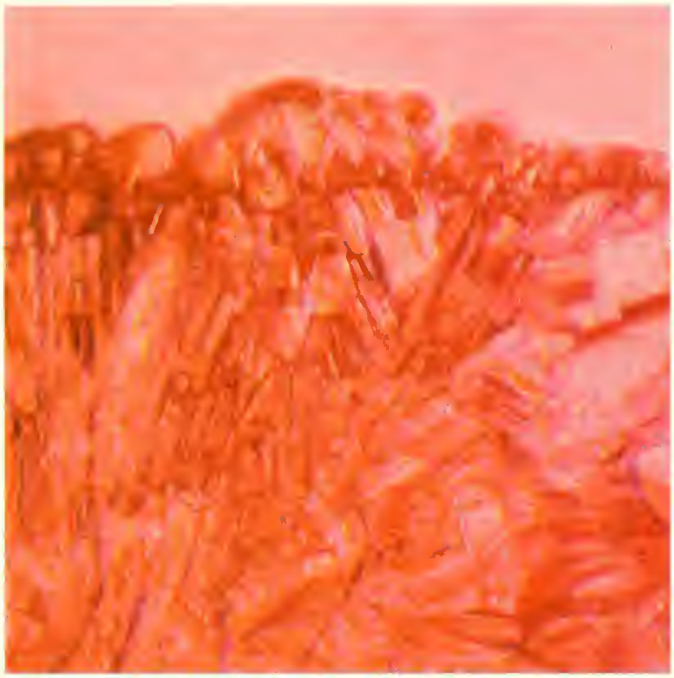
1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing information)

A different salicylate structure—
with no coating, no buffering
and it is sodium free

magan®
(Magnesium Salicylate, W-T)

microphotograph of magnesium salicylate crystals



Composition: Each orange-colored compressed tablet contains 5 grains (approximately 325 mg.) of magnesium salicylate, W-T (salicylic acid equivalent 75%).

Actions, Indications, Uses: The analgesic, anti-inflammatory, and antipyretic effects of MAGAN are similar to those of aspirin and other salicylates. Accordingly, MAGAN is indicated for the treatment of rheumatoid arthritis, osteoarthritis, nonarticular rheumatism such as bursitis, painful-shoulder syndrome, tendosynovitis, fibrositis, and other musculoskeletal disorders. The drug is also useful for the symptomatic relief of pain, aches, and discomfort of headache, neuralgia, minor injuries, dysmenorrhea, common cold and other minor infections of the respiratory tract. MAGAN (Magnesium Salicylate) may be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Contraindications: Because of the danger of hypermagnesemia, MAGAN is contraindicated in cases involving advanced chronic renal insufficiency. MAGAN, as other salicylates, may counteract the effect of uricosuric agents, and should not be prescribed for patients on such drugs.

Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

How Supplied: Bottles of 250 and 1000 tablets.

WARREN-TEED PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215
SUBSIDIARY OF **ROHM AND HAAS COMPANY**

ing such facts and information as he may think useful to the Society or beneficial to the profession at large.

ARTICLE 6 — It shall be the duty of the president or, in his absence or disability, the vice president, at each stated meeting to appoint one or more members to prepare essays on some subject medical or philosophical which shall be read and submitted to the Society at their meetings.

ARTICLE 7 — It shall be the duty of the presiding officer on application of any member of this Society, about to remove from this District, to give such applicant a certificate of his membership and standing in the Society.

ARTICLE 8 — The Society shall procure a seal with this device, viz.—the square and compass and enclosed with the motto — "The Medical Society of the Thirteenth District, Ohio."

ARTICLE 9 — The fines, assessments, and compensation of the officers shall be determined by the Society at their next annual meeting.

ARTICLE 10 — We, the undersigned officers and members do hereby pledge ourselves to abide by and support the Bylaws of this Society.

Signed—Silas Allen, Ezra Clark, Robert McNeill, J. H. Harris, James White, E. L. Minor, Jas. Michael Shaug, R. Culver, Wm. Talbott, Simon Hyde, Robert Turner, P. M. Morris, S. S. Geohegan, M. C. Crider (M. Z. Kreider), John Harris.

As Dr. Beery indicated in his article, some of these names were added some time later, after the persons named were licensed to practice. Such will be indicated further along in this article.

New Members and Other Business

A perusal of the minutes reveals that Reuben Culver of Hocking County was the first doctor to be licensed by the Society, May 26, 1824. Dr. P. M. Morris of Zanesville and Simon Hyde were licensed May 31, 1825. Drs. S. S. Geohegan, John Harris, and M. Z. Kreider were admitted on November 8, 1825. Dr. William Awl, of Perry County was admitted to membership on May 30, 1826. In November 1826, Dr. John Harris withdrew his membership following a dispute involving a censure of him. It seems that Luke Helmick had been admitted to membership with the aid and connivance of Dr. Harris, by means of an irregular procedure, whereupon Mr. Helmick's license was revoked. There seems to be some justification for this action, since Mr. Helmick failed to pass the examination held by the Censors on May 31, 1827. At this meeting Dr. James Ewing of Monticello was admitted by means of a transfer from Zanesville. William Talbott had moved out of the District.

Luke Helmick was apparently determined to practice medicine. After the events mentioned above, he was undaunted and at the meeting in November 1827, he was finally granted a license, along with Drs. Hugh H. Waite and A. C. Thompson. Dr. Helmick was apparently an individual whose personality invoked either loyalty or pronounced hostility. Evidence of this dedication is that on May 2, 1828, charges were preferred against him and a trial was held. The charges were not sustained and he remained in good standing. At this meeting Drs. Burton Creal and Thomas Hersey were admitted. On November 11, 1828, Dr. William Everett of Somerset, Perry County, was elected to membership.

It was not only difficult to gain admission to the Society but also to withdraw from it. On May 26, 1829, the application of Dr. Burton Creal to withdraw because of removal from the District was refused. Likewise applications of Drs. Ezra Clark and David Pardee to withdraw on account of their age were refused. There was plenty of business at this meeting. A certain doctor was expelled from the Society because of his alleged encouragement of quackery.

Two promising young men, John Milton Bigelow and Robert H. Curren were nominated to receive a course of lectures gratis at the University of Cincinnati. The former was selected because of seniority. Dr. B. W. Holmes was admitted to the Society. The next year Mr. Curran received the benefit of the Society's largess to attend the University of Cincinnati. At this meeting, Drs. J. M. Bigelow, James Hiland, and William M. P. Quinn passed an examination and were admitted. Dr. Bigelow opened an office in Lancaster while Dr. Quinn went to Baltimore.

The last meeting was held on May 29, 1832, in Lancaster. James Mahon was examined and granted a license. Officers were elected as follows: President, James White; Vice-President, S. S. Geohegan; Secretary, L. Wolfley; Treasurer, Daniel Kemper; Censors, L. Wolfley, M. Z. Kreider, Simon Hyde, Rueben C. Culver, and J. M. Bigelow. Dr. Paul Carpenter was admitted to membership. Mr. Benjamin Carlisle was chosen to attend a course of lectures at the Medical College of Ohio (at Cincinnati). The General Assembly repealed the Act in 1833, and so the medical districts and societies were dissolved. Thus ended a brief experiment in the regulation of medical practice.

Resumé of the District Society

These minutes give us an idea of the number of licenses granted and also of the earnest endeavor of the early practitioners to promote high standards of personal and professional conduct. Judging this Medical Society by our present standards one must admit that its goals and achievements were quite commendable. Adequate minutes were recorded, applicants were licensed, and, even more praiseworthy, a few were rejected. The members faced up to their responsibilities and even expelled a member for unethical behavior. The meetings, while infrequent, were conducted according to acceptable parliamentary procedure. A scientific paper or essay was read and discussed at each meeting. A library committee was appointed. A delegate was appointed to attend a state medical meeting. The Society encouraged promising young men to study medicine by sponsoring them for a course of lectures at a medical college. The members made an earnest effort to make the Society a nucleus for the exchange of medical knowl-

edge. Some medical societies of today cannot boast of higher goals.

A Review of the Membership

Of the majority of doctors mentioned previously in this paper, only too little is known of their lives. The members from Hocking County were Drs. Whipple, Culver, and Kemper; those from Perry County were Drs. Pardee, Awl and Everett. The careers of these gentlemen will not be further pursued since this paper deals primarily with medical men of Fairfield County. Dr. Robert Turner was an early practitioner in Rushville, although Dr. Hyde outdated him in practice by a few years.

DR. M. Z. KREIDER

One of the most colorful and illustrious personalities of early Fairfield County was Dr. Michael Zimmerman Kreider who was born in Huntingdon, Pa., being the first child of Daniel and Salome Zimmerman Kreider, both of Swiss-German descent. After the death of the mother in 1820, the family broke up. Michael, about 18 years old, took one of his younger brothers and one horse and, using the method of ride and tie, travelled over the Allegheny Mountains to near Tiffin, Ohio, where he found relatives with whom he remained for a time. About 1823 he went to Columbus, then a town of only two or three thousand inhabitants, and entered the office of Dr. Samuel Parsons as a student. Dr. Parsons was a graduate of Harvard, a skilled physician and an excellent business man. A man of literary tastes, he owned a library of medical and classical literature. While serving his preceptorship, young Michael took advantage of the opportunity to gain more knowledge from the excellent reading matter. After completion of his studies, he was licensed to practice medicine on November 8, 1825, by the Thirteenth District Medical Society as noted above. He began to practice in the village of Royalton, Fairfield County, and soon had a busy practice.

This brilliant young man in a few years began to explore new horizons. He was endowed with an unusual intellect, gifted with leadership, adorned with a pleasing and forceful personality as well as talented as a brilliant conversationalist and public speaker. With these virtues, he generated a tremendous ambition to achieve unusual heights.

To attain his goals more readily, he moved to Lancaster about 1832. In that year he was elected a Representative from Fairfield County to the General Assembly of Ohio for one term. In 1833, he was appointed Clerk of the Court of Common Pleas and served in that capacity for seven years.

His Contribution to Masonry

During this time, he became interested in Freemasonry and received the Degrees of Lancaster Lodge #57 in 1831. Later the Degrees of the Chapter, Council, and Commandery were conferred on him. He served as Master of Lancaster Lodge in 1843, and Commander of Lancaster Commandery, Knights Templar from 1844 until his death in 1855. Mainly as the result of his leadership and vision, the Grand Commandery Knights Templar of Ohio was organized in Lancaster in 1843. He served as the first Grand Commander. Four years later, he was elected Grand Master of the Grand Lodge F. & A. M. of Ohio and was reelected in 1848 and 1849. In addition to these activities, he continued to practice medicine, participated in church functions, operated a drug store, and owned and operated a stage coach company.



Dr. M. Z. Kreider

He became convinced of the realities of the Christian faith, and in 1842 he became a member of the First Methodist Church of Lancaster. In the following year, he was constituted a local preacher and was ordained a deacon in the church in 1847. He was an advocate of temperance and delivered lectures on that subject.

The field of medicine remained his prime interest. This encompassed surgical as well as medical practice. A list of the surgical operations performed by him included amputations, ovariotomy, resection of the maxilla, and lithotomy. He was said to have treated some surgical diseases of the eye, and practiced dentistry when the occasion demanded it. His interest in organized medicine continued after the Thirteenth District Medical Society was abolished. He began attending various medical meetings in the State and was a charter member when the Ohio State Medical Society was organized in 1846. He was issued a certificate of a charter member dated May 14, 1846. His interest in training young men for a career in



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†STEDYTABS Delfeta-sed ®

•**SEDAFAX** (brand of special micronized grade of AMOBARBITAL - Warning: may be habit forming).....**120 mg.**

•**DELFETAMINE** (brand of dl-N-METHYL-AMPHETAMINE HCl).....**30 mg.**

Usual Adult Dosage: **One tablet daily. To be taken in the morning.**

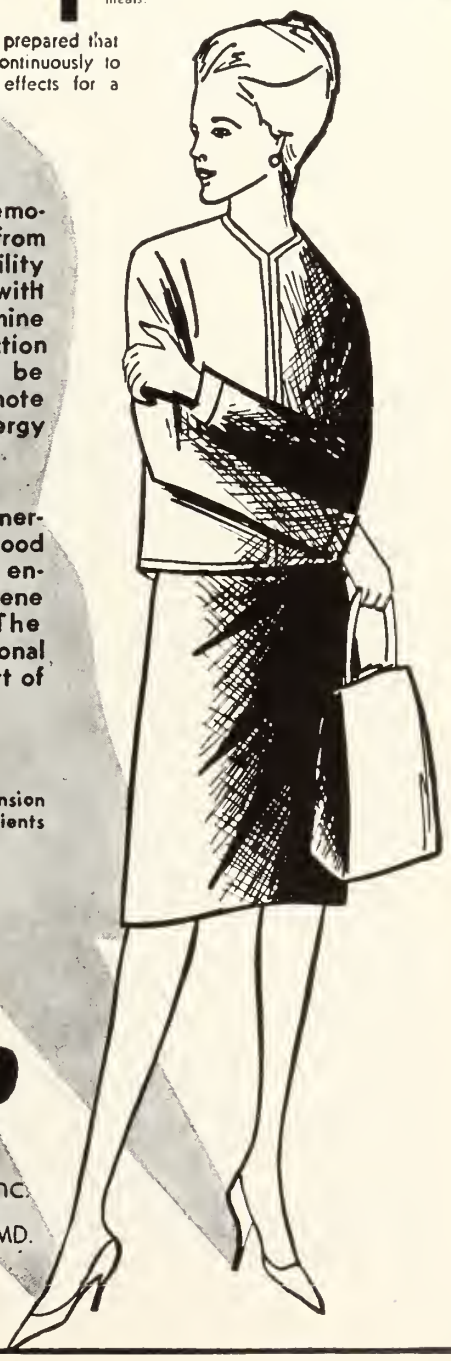
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•**SEDAFAX** (brand of special micronized grade of AMOBARBITAL - Warning: may be habit forming).....**40 mg.**

•**DELFETAMINE** (brand of dl-N-METHYL-AMPHETAMINE HCl.).....**10 mg.**

Usual Adult Dosage: In obesity, 1 tablet t. i. d. 30-60 minutes before meals. In all other conditions, take 1 tablet t. i. d. immediately after meals.

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medicine induced him to offer his services as a preceptor. At one time there were four students taking the preceptorships.

About 1850, he was appointed a member of the Board of Trustees of Ohio University at Athens. He was well known in central and southern Ohio, as a genial, entertaining, and witty person with a commanding presence and an indomitable energy. He was a large broad shouldered man, well proportioned with a large nose, bright eyes, and a generally keen and alert expression. In every assemblage by his inimitable wit, versatility in anecdote, and gift of memory he collected a crowd around him which he never failed to interest and instruct. (Figure 1.)

In 1853, while traveling in Michigan, he suffered a sunstroke. Soon thereafter, diabetes mellitus was manifested. Within a year or so this was complicated by pulmonary tuberculosis. Later, pulmonary hemorrhages weakened him and he died on July 20, 1855. His funeral was conducted by the Grand Lodge F. & A. M. of Ohio which erected a large monument to his memory at the site of his grave in Elmwood cemetery in Lancaster. The M. Z. Kreider Chapter #145, Order of Eastern Star, of Lancaster, was organized in 1901 and named in his honor.

Dr. Kreider was married twice. He wed Sidney Ann Reese, daughter of General David Reese of Lancaster in 1825. Four daughters and one son were born to this union. Mrs. Kreider died in 1843. For his second wife he married Mary Ann Carpenter in 1844. Two children were born of this marriage neither of whom married. A grandson studied medicine and practiced in Springfield, Illinois. A great-grandson also graduated from medical school and lives in Springfield.

(To Be Concluded in July Issue)

Information Given on Operation Of Medic Alert Foundation

The following "Ten Facts About Medic Alert" are presented for the information of physicians virtually as they were prepared for distribution by the Medic Alert Foundation, Turlock, California 95380.

1. The Medic Alert Foundation is a nonprofit, charitable, tax-exempt organization (501(c)3 rating with the IRS), founded in 1956 and dedicated to educating and encouraging individuals to wear on their person identification of any medical problems that should be known in an emergency. Equally important is to have all medical facts registered in one central file. An additional goal is to urge physicians and all other medical personnel to advise persons of the importance of wearing such identification at all times, as well as to have their medical information filed where it can be obtained quickly in an emergency.

2. To accent the vital message of an existing medical problem, the Foundation distributes a metal em-

blem that bears the symbol of the medical profession; the words, "Medic Alert," emblazoned in red on the face of the emblem; and the symbol for medical identification adopted by the American Medical Association. A medical information wallet card is provided with each emblem. The membership fee is $7.00, which includes a bracelet or necklace in stainless steel and one medical problem engraving. The fee is $9.00 for sterling silver emblems and $25.00 for 10 carat gold-filled emblems.

3. On the reverse side of the emblem is engraved the **immediate** medical problem(s) of the wearer. A few examples are: "Diabetes," "Allergic to Penicillin," "Taking Anticoagulants," "Wearing Contact Lenses," "Neck Breather," "Epilepsy." Additional medical information and other personal information is filed in the Central Answering File.

4. The Central File accepts, on a 24 hour a day basis, collect calls when necessary from authorized persons (physicians, emergency hospital room personnel, law enforcement officials, etc.), then relays additional information from the file which pertains to the wearer. Each emblem is registered and the serial number is engraved on the reverse side, as is the telephone number of the Central File (209 634-4917). A percentage of each membership fee goes into a trust fund to perpetuate this vital service.

5. More than 200,000 Americans wear Medic Alert emblems. More than 2,000 join monthly.

6. The Foundation conducts a continuous educational program to professional people and the general public.

7. The Board of Directors is composed of physicians, corporation executives, and leading businessmen. The Medical Advisory Committee and the National Advisory Board are, for the most part, composed of persons who are interested in or who actually administer first aid in an emergency.

8. The Foundation receives publicity from newspapers, magazines, radio and television, trade and corporate publications.

9. Affiliate organizations have been established and are governed by their own Board of Directors in ten other countries: Australia, Belgium, Canada, Great Britain and the Republic of Ireland, Malaya, The Netherlands, New Zealand, The Philippines, South Africa, and Spain. The Medic Alert emblem is registered in 24 other foreign countries.

10. The Medic Alert Foundation has been endorsed by a large number of national organizations. In addition, many state and county medical societies, pharmaceutical, nurses, medical assistants, farm bureaus, and service club groups have also endorsed Medic Alert. Numerous of these actually assist Medic Alert in its educational program. Some provide emblems to the indigent. The Foundation needs and encourages contributions, endorsements and publicity.

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A Review of Current Concepts And Research in Shock

JAMES M. BLACKFORD, M.D., JAMES D. BOWERS, M.D., and DAVID K. HEYDINGER, M.D.

THE DEFINITIONS of shock in the past century have varied from the philosophical description by the elder Gross in 1872 ("Shock is a manifestation of the rude unhinging of the machinery of life")[247] to the scientific and complex definition recently proposed by Simeone ("Shock is a clinical condition characterized by signs and symptoms which arise when the cardiac output is insufficient to fill the arterial tree with blood under suffcient pressure to provide organs and tissues with adequate blood flow."[248] With shock research becoming more intently focused at the cellular level, it is now logical and perhaps necessary to define shock as *a basic defect of cellular perfusion.* Perfusion is the process by which individual cells receive oxygen and glucose from the blood and in turn release their metabolites for excretion. Therefore, shock is a basic interference in the metabolic production of energy within the body.

Classification

Numerous classifications of the shock process have been advanced but the simplest classification appears to be a logical way to include all of the various types of clinical shock. It provides that the human cardiovascular system is divided into essentially three main components;[238] a pump (the heart), a fluid medium (the blood volume), and a reservoir and conduit system (arteries, veins, and capillaries). Failure of the pump is called *cardiogenic* shock and is seen following myocardial infarction, cardiac arrythmias, cardiac tamponade, or tension pneumothorax. The most commonly observed form of clinical shock is that due to *volume loss* and is seen in hemorrhage from any cause, plasma loss due to burns, or loss of large quantities of interstitial fluid as is seen in dehydration. The third type or, *reservoir* shock, is less common, contributing to neurogenic, anaphylactic, and probably to endotoxin shock.

Missing factors from this simplified classification, however, are (1) the individual cells; (2) the extracellular, extravascular tissue; and (3) the com-

The Authors

- **Dr. Blackford, Columbus, is Senior Assistant Resident in Surgery, Riverside Methodist Hospital.**
- **Dr. Bowers, Columbus, is a member of the Attending Staffs of Riverside Methodist Hospital and St. Ann's Hospital.**
- **Dr. Heydinger, Columbus, is a member of the Senior Attending Staff of Riverside Methodist Hospital; Courtesy Staffs of University, Children's, and Mount Carmel Hospitals; Associate Professor of Clinical Surgery, The Ohio State University College of Medicine.**

From the Department of Surgery, Riverside Methodist Hospital, Columbus, Ohio, and the Riverside Methodist Hospital Research Foundation. Submitted January 25, 1968.

plex nervous and humoral factors affecting the system. It is within these three categories that the concept of "irreversibility" of the shock process arises, and it is also here that the majority of present research is being accomplished.

Historical Aspects: The importance of fluid volume was recognized as early as 1831 when Thomas Latta administered saline intravenously to a cholera patient with dramatic improvement.[179] In 1899 George Crile reemphasized the importance of circulating volume and advanced the concept of the importance of venous pressure in shock due to blood loss.[210]

The contributions of the reservoir system to the pathogenesis of shock were noted by Claude-Bernard, Brown-Sequard, and others with the advancement of the "neurogenic theory of shock," which advocated inhibition of vasomotor centers and peripheral pooling of blood.[179] Erlanger,[64,65] and others[7] during World War I noted the vasoconstriction which occurred early in shock and stated that the decrease in reservoir size was likely more harmful than beneficial.

The importance of the heart in shock was described by many investigators, including Starling, Guyton, and Crowell,[25,53,54] and the beneficial effects of digitalis and the cardiotonic drugs in the shock state were noted.

More recent research work has become focused on the study of the minute pathophysiologic mechanisms occurring in shock: the microcirculatory and humoral changes (Fine, Lillehei, Hardaway and others); the cellular and metabolic effects (Wilson, Weissman, Eiseman, Thomas and others); and the extracellular, extravascular disorders (Shires, Moyer, Sapirstein and others).

Clinical Effects and Homeostasis: Shock seen by the clinician is not a pathologic entity in itself but rather the result of a unique complex of physiologic reactions occurring within the body in response to the shock stimulus.[186] These mechanisms are generally referred to as "homeostasis" or, teleologically, "the striving of the organism to maintain its functions at a level compatible with life."

Shock basically begins when there is a reduced cardiac output or a reduction in cellular perfusion.[182] Immediately following either of these stimuli there is an increase in sympathetic nervous activity and a rapid rise of the catecholamine level in the peripheral blood.[158,200] This is initiated as a result of decreased stretch in the pressure receptors of the carotid sinus[168] and is mediated via the hypothalamus, medullary vasomotor centers, and the sympathetic nervous system,[80] with release of norepinephrine at nerve ends.[3] An additional quantity of catecholamines is also supplied by the adrenal medulla in response to the stimulus of stress.[220]

The main effects of these catecholamines are (1) an increased rate and force of myocardial contraction, (2) constriction of arterioles and venules in skin, kidney, and abdominal viscera;[67,73,111] (3) dilatation of arteries in skeletal muscle and myocardium;[79] and (4) increased glycogenolysis with resultant hyperglycemia.[16] The directly observable results are: (1) an increase in the cardiac output;[111] (2) a shunting of blood directly from arterioles to venules by opening up previously unused arteriovenous shunts;[19,111] and (3) an increased venous pressure resulting in increased venous return to the heart.[45]

The second major homeostatic mechanism is indirectly a result of the first: When the volume flow through the capillary beds is reduced, there is, according to Starling and others,[80] a reduced hydrostatic pressure within the capillaries and a subsequent reversal of the existing capillary-extracellular fluid pressure gradient.[141] This allows fluid to move from the extracellular space into the vascular compartment.[160] As a result there is a hemodilution of the formed elements of the blood but, more important, an increase in the size of the circulating volume: in effect an autotransfusion with increased volume returning to the heart.[161] It has also been demonstrated that increased lymphatic flow also plays an important role in autotransfusion, especially in endotoxin shock.[249]

A third homeostatic mechanism is, again, directly related to improving the effective fluid volume with the preservation of water and sodium by the kidney.[210] This is mediated partially by the hypothalamic stimulus to release ADH (antidiuretic hormone) and partially by the release of aldosterone from the adrenal gland.[201] This latter mechanism occurs under the stimulus of angiotensin, which is a polypeptide produced by the action of renin from the juxtaglomerular cells of the kidney on a plasma protein precursor.[185,213,250,259]

Additional homeostasis is provided by the respiratory system which undergoes intense hyperventilation secondary to the stimulus of hypercapnea and metabolic acidosis on body chemoreceptors.[49,102,108,210,211] For a short time this compensates for the lowered pH by eliminating excess carbon dioxide.

If the initiating stimulus of the shock state is mild, transient, or adequately controlled by treatment, then these homeostatic mechanisms have been truly beneficial;[226] they have shunted blood from nonvital to vital areas with preservation of myocardial and cerebral function. If, however, the stimulus or etiologic agent is severe, protracted, or inadequately treated, these same mechanisms become the means of furthering the shock process.[183]

Pathophysiology

When there is prolongation of sympathetic stimulus the following results are observed:

(1) Cellular anoxia ensues, due to the arteriovenous shunts and the bypassing of the capillary

beds, with loss of the perfusion system for specific cells.

(2) The renal flow, which normally is approximately 25 per cent of the circulating volume, drops to 7 to 10 per cent in the shock state.[195,210,251] With prolongation of this anoxia, focal tubular necrosis[39] and oliguria[143,192] may result and a loss of the hyperosmolar zone in the renal medulla may seriously impair future water and sodium regulation by the kidney.[171]

(3) The constant vasoconstrictive stimulus causes the precapillary arterioles to very quickly lose their tone, and, when coupled with metabolic acidosis[173] and the accumulation of vasodilator substances, they will actually dilate, allowing the capillary bed to become engorged with blood. However, as shown by Lillehei and others,[6,128,129,130,157] there is no ablation of "sphincter activity" on the venous or "outflow" side of the capillary bed. The net result is a peripheral "trapping" of blood with conversion of ischemic anoxia to stagnant anoxia.

(4) the prolonged sympathetic activity in the dog very quickly leads to splanchnic entrapment of blood[42,43] with mucosal ischemia,[66] ulceration, and GI hemorrhage.[30,94] In man, the GI tract and splanchnic vasculature appear less vulnerable and these lesions are both infrequent and less severe.[210,223] However, there is much recent evidence to suggest that a similar entrapment of blood occurs in the pulmonary vasculature in man, with marked congestion and hemorrhage into the lungs.[128,142,172]

The hemodilution and fluid shifts which occur also have been found to have harmful effects. Shires and others[176,178] have shown conclusively that the mortality rate significantly increases in dogs subjected to hemorrhagic shock if the extracellular deficit is not replaced during thrapy.

Hyperventilation, which initially reduces carbon dioxide tension to compensate for the metabolic acidosis, very quickly leads to hypocapnea,[36] and the metabolic acidosis becomes complicated by a respiratory alkalosis which makes treatment quite difficult.

Pathophysiology and Irreversibility

It is therefore apparent that sympathetic activity, autotransfusion, and hyperventilation are not a solution to the shock state, but they may actually complicate it. They are, in fact, significantly involved in the concept of "irreversibility" in shock.

Irreversibility is a concept which cannot adequately be defined or limited;[229] suffice it to say that when the shock state has reached a certain point, further replacement of fluid and administration of therapeutic agents are of no avail and death is inevitable. Much of the present research on shock is concerned with irreversibility and methods of extending the reversible stage as well as attacking the factors involved in irreversibility.

A. **Myocardial Failure:** In the theory of irreversibility proposed by Guyton and Crowell,[53,54] primary failure of the heart was considered to be the main etiologic factor. Although cardiac failure is common to shock and a terminal event in almost all types of shock, it is considered by most to be of secondary rather than primary importance in causing irreversibility.[4,71,122,190]

B. **Disseminated Intravascular Coagulation (DIC):** Hardaway has long advocated the importance of a syndrome called "disseminated intravascular coagulation."[88,89,90,91,93,94] He believes that low flow states, coupled with metabolic acidosis[86] and a hypercoagulable state of the blood,[11,62,83] or with coagulating substances introduced into the blood,[89,90,95,98] are capable of producing red blood cell aggregation and antemortem thrombi in small capillaries. The manifestations of this are a hemorrhagic tendency,[62,87,95,96] decreased venous return to the heart,[159] and focal organ necrosis.[88,89,97]

In a recent study of 32 cases of protracted shock compared to ten cases of instantaneous death,[84] he found histologic evidence of antemortem thrombi in 90 per cent of the cases, compared to none in the control group. In 23 of these 32 patients, unusual globular clots were found in the circulating blood before death. The clots appeared to be altered red blood cells which had released their hemoglobin, which in turn was redistributed in the periphery and became coated with fibrin.[97] Many investigators have shown that blood viscosity increases with a decrease in flow rate,[170,181,228] and associated with this is a tendency for red cells to aggregate,[120] to undergo rouleau formation, and to become coated with fibrin, especially under the influence of platelet-released serotonin. This could explain the formation of these globular clots, some of which reached 200 microns in size, and which could easily obstruct small capillaries.

C. **Cellular and Enzyme Changes:** Only recently has the importance of the cell and its enzyme systems become known in the shock process. With the onset of cellular anoxia the metabolism of the glucose molecule is unable to proceed through decarboxylation of the pyruvate molecule; therefore, acetyl-Co-A becomes unavailable for use in Kreb's cycle.[210] Instead, pyruvate is converted to lactate by the acceptance of hydrogen ions. Utilizing this pathway, there is a markedly reduced amount of energy produced per molecule of glucose, as compared to that produced using the Kreb's cycle and electron transport system. Within the cell, therefore, the mitochondria produce less adenosine triphosphate (ATP) and consequently fewer of these high-energy phosphate bonds are available for protein synthesis on the endoplasmic reticulum. A fur-

ther consequence of anoxia is the disruption of the lysosomal membrane with release of proteases and esterases into the cell and into the circulation.[17,227] Therefore, the sequence of anoxia, decreased energy production, decreased protein synthesis, and release of destructive enzymes characterizes the individual cell's contribution to irreversibility.

D. **Reticuloendothelial System Depression:** Fine and others[68,69,70,71,153,252] have advanced the theory that in many cases of prolonged shock of any nature, toxemia and specifically endotoxemia play an extremely important role in irreversibility. He and his co-workers have actually bio-assayed endotoxin from the blood of animals late in hemorrhagic shock.[70] There is also evidence that the spleen is ordinarily capable of detoxifying endotoxin, but in the shock state it becomes functionally depressed as does the remainder of the reticuloendothelial system.[5,26,27,28,70,155,196] The specific importance of toxemia is still controversial. Various investigators have shown germ-free animals to respond essentially the same as normal animals to hemorrhagic shock,[165] stating that this tends to disprove the importance of bacterial infection. Others have attempted to stimulate the reticuloendothelial system using lipids or the yeast extract, zymosan, and found that survival is not increased.[239,240] Preliminary work by Nick et al indicates the presence of DNA specific antibodies in the serum of humans in prolonged shock and raises the possibility of specific nucleotide replacement being of some value in the treatment of resistant shock.[264]

E. **Extracellular Fluid Changes:** Recent work by Shires and Moyer has disclosed another area which may contribute to irreversibility – the role of the interstitial tissue and fluid.[34,176,177,178,179] Using sulfur-35 labeled sodium sulfate, Shires found that dogs bled 25 per cent of their volume had actually lost 18 to 26 per cent of their extracellular fluid *without evidence of significant external loss.*[179] Applying the same measurement techniques to man in shock, he found the average extracellular fluid loss to be 31 per cent or almost 4,500 cc.[52,178] This loss of water and salt was originally ascribed to movement into the vascular system and into the cells, postulating that as sodium moved into the cell, potassium moved out of the cell with a concomitant rise in serum potassium levels.[176] This has led to some controversy, since Moyer and others[35] have shown that the small elevation of serum potassium seen in shock[160] could not possibly account for the large quantities of sodium lost, nor could it be explained by increased capillary permeability, since capillaries are normally freely permeable to both sodium and water. In an experiment using sparsely-celled rat's tails, Broido and Moyer[34] demonstrated that much of the sodium and water was, in fact, absorbed on the macromolecules of the interstitial ground substance, even when no vascular attachment existed.

Further importance of the ground substance has been proposed by Sapirstein[169] who feels that capillary endothelium is at all times freely permeable to *everything* except red cells and that there is a membrane between the pericapillary space and the lymphatic across which hydrostatic and colloid pressures are exerted. He further postulates that any so-called "changes in capillary permeability"[18,24,151,191,253] which have been stated to occur are in effect changes in the gel which constituted the ground substance.

F. **Visceral Pooling of Blood:** Lillehei[128-131] has studied the factors concerned with irreversibility in various types of shock and has concluded that the basic pathologic hemodynamic mechanisms are similar. According to his concepts, the basic problem in irreversibility is the progression of ischemic anoxia to stagnant anoxia with progressive pooling of blood in the capillary beds of viscera and finally extravasation into the tissues.[129,131,164] In the dog, the so-called "target organs" are the abdominal viscera; recent studies in man implicate the lung as the site of action.[128, 142, 210]

G. **Vasoactive Substances:** Numerous studies have been made on the contribution of "vasoactive substances" to irreversibility of shock and there are conflicting opinions as to their importance.

Histamine is a potent local vasodilator, which causes a drop in the systemic resistance[118] associated with a marked rise in pulmonary vascular resistance.[8,172] It has been assayed in elevated levels in the serum of dogs after the administration of endotoxin and in some cases of anaphylactic shock.[217] Despite the vasodilatation at the metarteriole level, there is evidence to suggest that it also causes venous constriction and may contribute to the rise in splanchnic venous resistance in the dog. Increased tissue levels of histamine may also explain the persistence of "sphincter constriction" on the venular side of the capillary bed.

Serotonin has been measured in increases approaching 600 per cent in the splanchnic venous blood of shocked dogs using radioisotope technics.[206] This substance, found mainly in platelets and brain tissue,[162] is proposed to contribute to red cell and platelet aggregation.[20,205] Serotonin is also a vasoactive substance and is thought to have an amphibaric effect, i. e., it acts opposite to the force which is already existing on the vessel.[210] There is evidence to suggest that it may be sequestered in the lung, contributing to the rise in pulmonary resistance.[206]

Bradykinin[48,208] is a polypeptide which is formed by the action of a protease on a plasma globulin. Studies in various animals have demonstrated transient increases of bradykinin during various types of shock (notably anaphylactic and septic), and also shock associated with pancreatitis.[203] It has been

found to regulate the caliber of small vessels by causing vasodilatation in skin and muscle. It is also a potent coronary vasodilator.[210]

Kallidin[208,209] also is a polypeptide and is formed by the action of a protease (kallikrein) on an alpha-2-globulin. It is of importance mainly in shock associated with pancreatitis, probably reducing the peripheral resistance, and it may also have a synergistic effect with endotoxin.[222]

Angiotensin[210] is produced as a result of the stimulus of reduced renal blood flow and apparently stimulates the production of aldosterone by the adrenal gland. It also has very potent hemodynamic effects, including depressing the cardiac output and causing considerable increase in peripheral vasoconstriction. Paradoxically, its most detrimental effects are on the kidney where it increases renal resistance and further depresses renal blood flow.[146]

Endotoxin and *exotoxin* are the object of much intensive research.[33,106,107,109,113,118,123,149]

Exotoxin, particularly from Staphylococcus, has been shown experimentally to cause severe contractions of vascular smooth muscle[210] and also to be a potent liberator of both histamine and serotonin.[113,209] *Endotoxin* is a complex lipopolysaccharide produced from the cell wall of gram-negative bacteria. Its actions are incompletely understood and extremely controversial.[145,147,163,164,165] It has, in itself, no effect on isolated smooth muscle preparations, but, clinically it appears to drastically intensify peripheral vasoconstriction.[151,194,200] In man, endotoxin has been postulated to have a direct toxic effect on the blood vessels,[241] particularly the pulmonary vascular bed where it causes marked pulmonary congestion,[210] and also to directly inhibit myocardial contractility.[261] When incubated with blood or homogenized tissue, it has been shown to release histamine,[118] enzymes,[272] and other vasoactive substances.[104,107,113,162,199,217]

There are many discrepancies in individual reactions to endotoxin, probably depending on such factors as dosage, host resistance, species, and previous sensitization.[33,106,107,109] In fact, recent studies in man suggest that sublethal doses may cause aparadoxical increase in cardiac output associated with systemic vasodilatation. It is perhaps the most difficult form of shock to treat, is associated with high mortality rate,[204] and generally is considered a puzzling enigma, which apparently is being recognized with increasing frequency.[226]

Treatment and Research

Because of the various etiologies and the multitude of hemodynamic alterations that may occur, there is no such thing as "standard therapy" in shock.[75] Each patient must have accurate hemodynamic measurements before any type of therapy can be instituted[115,117,129,132,231,235] Much of the present day therapy is based largely on experimental work in animals and, therefore, is subject to a great deal of controversy. The basic goals of treatment are, however, similar: to improve the *effective circulating volume* and to improve *cellular perfusion.*[210]

Drugs: The prime objectives in shock treatment until World War II, were replacement of blood and elevation of the arterial pressure. There are few things quite so dramatic as the instantaneous elevation of blood pressure from shock levels to normal levels by the administration of a vasopressor drug — yet, as recent work has proven, there is nothing more detrimental to the eventual recovery of the patient.[47] Even though vasopressor agents are now generally recognized as harmful, there continues to be considerable discussion and controversy over their use in present literature.[22,37,46,47,83,93,103,105,112,128,148,160,179,182,188,189,193,194,221] The term "vasopressor drugs," however, is extremely misleading and should more correctly be "vasoactive drugs."[214,224]

Norepinephrine has a beneficial cardiac action[189,219] but only at the expense of reduced peripheral perfusion[37,105,112,118,212] and increased metabolic acidosis.[186] In doses normally used, norepinephrine has been shown to be almost a pure stimulator of alpha receptors[78] (which cause intense peripheral vasoconstriction).[103] Recent data have been published showing that if a smaller dose is used to keep the arterial pressure 30 mm. Hg. below *normal* levels, there is a paradoxical decrease in total peripheral resistance with no diminution of its beneficial cardiac actions.[22,58,125,197,234]

Mephentermine[214] and *metaraminol* are vasopressors which act at both alpha and beta receptors (causing peripheral vasodilatation) and both have been shown to reduce the mortality from cardiogenic shock by shunting blood to the heart and brain and improving coronary perfusion.[197]

Isoproterenol is also classed as a vasopressor. However, its action is primarily at the beta receptors[78,116,119,] with the result being an increased rate and force of cardiac contraction[55,215] associated with a *decrease* in peripheral resistance due to vasodilatation.[116,119,235]

Vasodilator drugs have recently been advocated by numerous authors. They consist of two groups: those which act by blocking the alpha-adrenergic receptors (phenoxybenzamine [15,61,78,81,99,113,130,131,144,167,216] and chlorpromazine)[47,81,138] and those which stimulate the beta receptors (isoproterenol and nylidrin).[265] These drugs decrease the peripheral resistance and increase peripheral perfusion but must be used in conjunction with massive intravenous fluid therapy to combat any existing hypovolemia.[1,2,93,212,218] Recent work also suggests that phenoxybenzamine may in addition have a cardiotonic effect and dramatically reduce pulmonary vasoconstriction.[233]

Despite initial enthusiasm over phenoxybenzamine, several investigators have been unable to prove that its use is of any more benefit than massive transfusion alone.

Berk has advocated yet another shock theory which may lead to the therapeutic clinical trial of another class of vasoactive drugs, the beta-adrenergic blocking agents. In his concept,[251] the excessive initial catecholamine stimulation has a more marked effect on the beta receptors, which results in peripheral vasodilatation and pooling of blood. This has prompted him to evaluate B-propanalol, a beta-blocking agent, which in his initial studies in dogs has proved to be of some benefit. The use of this drug is not without hazards, including decreased myocardial contractility, hypoglycemia, and occasionally a profound bradycardia.

Entman,[255] using a similar drug (pronethalol), found that beta-blockade, when used as pretreatment, prevented zonal lesions and subendocardial hemorrhage in dogs subjected to hemorrhagic shock.

Another therapeutic regimen of some controversy is the use of *adrenal steroids*. There is a general agreement that in most cases of shock there is no deficiency in the production of adrenal steroids.[63] A number of beneficial effects[128,160,194,223] were noted, however, with the use of pharmacologic doses. Sayers has demonstrated a direct positive inotropic effect of steroids on isolated heart muscle preparations.[221] Others have shown a direct adrenolytic effect with peripheral dilatation and increase in effective blood flow.[128,154,204] Weissman and Thomas recently demonstrated a third effect of steroids, when they were able to show that large doses of steroids stabilized the lysosomal membrane and prevented the release of damaging proteolytic enzymes.[227]

It is not surprising that many different compounds have at some time been reported of benefit in the treatment of shock when one considers the variety of physiologic derangements that occur.[193] *Aldosterone* has been shown to increase the survival rate in dogs.[29,101,124] *Hyperbaric oxygen* has been demonstrated to increase survival in all types of shock.[9,10,50,112] *Glutathione*,[202] and *cyanocobalamin* (Vitamin B_{12})[12] have been found by European researchers to increase survival in shocked rats when added to blood substitutes. *Nicotinamide* in doses of 500 mg./kg. has been shown by Moyer to be of definite benefit when administered to shocked rats.[175] *Epsilon-aminocaproic acid*,[137,198] *fibrinolysin*,[40,41,82,85,92,273] and *heparin*[85,94,237] have all, on occasion, been shown to have some beneficial effect in the treatment of shock. *Antihistamines, antikallikrein*, and *hypothermia* have been used experimentally with varying degrees of success.[23,44,51,59,152,184,210] It has recently been suggested that the increased survival seen in dogs treated with phenoxybenzamine may be due more to the fact that it is a potent antihistamine rather than to its vasodilating properties.[32,107] Recent work by Eiseman[174] has shown that ATP greatly increased survival when given to shocked rats and others have been able to duplicate these results in dogs.[207] Improved survival in endotoxin shock has been reported following administration of simple analgesic-antipyretic agents such as *sodium salicylate*.[242] Correction of metabolic acidosis and reduction of excess lactate have been claimed following administration of the ganglionic-blocking agent, *trimethaphan camsylate*.[243] Mayo has demonstrated a marked decrease in mortality following the use of *hemodialysis* early in shock, more effective in endotoxin shock than hemorrhagic, presumably based on the lethality of a dialyzable vasoactive substance.[256]

Fluid Replacement: Perhaps the most significant recent contributions have been made in the field of volume replacement.[121] Because of the delay in blood replacement (due to necessity for crossmatching), various volume expanders have been developed. *Plasma*, when stored for six months, is an extremely effective volume expander that does not carry the risk of hepatitis. *Serum albumin*[157] and *hydroxyethyl starch*[14,275] are known effective blood substitutes, although recent work has suggested the development of a hemorrhagic tendency with the latter.[127] *Dextran*[13] and low-molecular-weight *dextran (LMWD)*[110,170,181,230,232,263] are currently being used quite effectively. They are rapid blood compartment expanders and have a definite antithrombotic effect, while LMWD has the additional ability to reduce red blood cell aggregation, rouleau formation, and platelet stickiness.[126,150,268]

The best replacement for blood lost, however, is whole blood,[177] and the importance of blood and replacement of the extracellular fluid deficit has been reemphasized by Moyer.[57] Using a standard shock preparation in dogs, he presented a number of statistically significant and valid conclusions concerning volume replacement. Replacing the blood lost plus an equal amount of lactated Ringer's solution of pH 8.2 is the treatment of choice. This can, however, be matched in effectiveness by giving one half the blood lost plus Ringer's lactate in volumes equal to two to three times the volume of the hemorrhage. He also presents evidence showing that the use of 5 per cent detrose in water or mannitol is of absolutely no value and in fact increased the mortality in his experiments. This report and others have attached increased significance to the use of buffered *isotonic sodium solutions* in the treatment of shock.[56,156,157,177,178,179,266,267,271]

An orderly regimen for the treatment of shock has been proposed by Wilson[231] and others,[21,55,115,117,129,132,135,136,270] which utilizes central venous pressure measurements (CVP), arterial-venous oxygen saturation differences, and an application of the known physiologic principles involved in the shock process. This regimen is quite simple and inexpen-

sive and can be utilized even in the smallest community hospitals.[134,225]

Following the establishment of an intravenous fluid route in the subclavian[60] or antecubital vein[133] with a long plastic catheter, the central venous pressure is measured, using a standard spinal fluid pressure manometer.[136,137] Arterial and venous blood samples are taken and quickly analyzed with an oximeter.

Low cardiac output states are usually associated with a high tissue oxygen extraction and, therefore, a high difference in the arterial and venous oxygen saturation. A low arterial-venous oxygen difference usually indicates high or normal cardiac output. Using these measurements, the first abnormality to be consideretd is *hypovolemia.* If the CVP is low or normal, the blood pressure low, and the A-V oxygen difference greater than 5 Vol per cent, then 250 to 500 cc. of an isotonic salt solution is given rapidly.[56] If the CVP remains low or rapidly returns to low levels, hypovolemia is present and massive transfusion is indicated.

The next step is the evaluation of the *cardiac status.* If the A-V oxygen difference is greater than 5 Vol per cent and the CVP is high or becomes high with minor transfusion, then cardiac insufficiency exists and should be treated with digitalis and/or isoproterenol[135,262]

The third factor to be evaluated is the *vascular tone.* If the A-V oxygen difference is normal or low, the CVP normal or low, and the blood pressure low; then a defect in vascular tone exists, with an increased reservoir capacity. It is here that perhaps the rare use of vasopressor agents is indicated.

If one adds the measurement of oxygen and carbon dioxide tensions and pH measurements to the above regimen, then the classification of patients in shock, especially septic shock, becomes even more meaningful. MacLean[257] recently described four groups of patients with correspondingly different prognoses in septic shock: *Group I.* Patients with initial high CVP and alkalosis with a survival of 24 out of 28; *Group II.* Initial high CVP and acidosis, with only one of 11 patients surviving; *Group III.* Initial low CVP with alkalosis in which eight out of 10 patients lived; and *Group IV.* Initial low CVP and acidosis in which all seven patients died despite adequate therapy. Therefore, it is readily apparent that CVP measurement, plus blood gas studies and arterial pH, affords not only the basis for effective treatment but is of some importance in prognosis as well.

A number of specific therapeutic measures must be added to this program. Replacement of blood should be accomplished as soon as possible in hemorrhagic shock.[157] Antibiotics and adrenal steroids should be considered, especially in endotoxic shock.[131,165,179,210,236] The dose of hydrocortisone should be in the range of 25 to 50 mg./kg. or its equivalent, which may be given daily in divided doses or given early in one massive dose in shock complicated by peripheral vasoconstriction. Initial antibiotics should cover a wide spectrum until appropriate sensitivity studies are available and should be given in adequate dosage.

Treatment of existing acidosis is important[100] and may be accomplished by the use of sodium bicarbonate[132] or trisbuffer solutions,[31,74,173,211,244] or if respiratory in origin, by appropriate ventilatory techniques (either the pressure regulated Bennett respirator or a volume controlled respirator such as the Engstrom unit).

Oxygen by mask, cannula, or chamber should be used frequently.[110] During severe shock, the replacement of vitamin and protein stores should not be neglected. Valuable assistance to respiration may be given by utilization of a tracheostomy or respirator, and cardiac assistance can be supplied by a cardiopulmonary bypass unit[49] or a diastolic augmentation unit.[46,47,276] Surgical removal of the source of infection may be of prime importance in the treatment of endotoxin shock.[165,258,269] In cases associated with vasopasm, the use of adrenergic blocking agents may offer dramatic help.[47,61,81,99,130] In shock associated with occlusion of a major abdominal artery, surgical or chemical denervation of the abdominal viscera should be considered.[245,246]

In order to improve shock therapy and attempt to clarify some of the divergent theories of shock, a number of larger hospitals have established special areas in the intensive care unit for refractory shock patients.[72,77] The advantages of such a clinical unit are obvious. Shock patients can undergo continuous intensive care and continued monitoring by electrocardiography and measurement of venous pressure, direct arterial pressure, cardiac output, plasma and extracellular volumes,[180] and arterial and venous blood bases,[166] and laboratory chemical analysis.

The main requirements for such a unit are the following:

1. Trained physicians in shock care 24 hours a day;
2. Specially trained nursing personnel;
3. Continuous laboratory facilities;
4. Monitoring devices to continuously measure and record the above parameters of shock;
5. Special respiratory and cardiac assist units; and
6. Cooperation of specially trained personnel, including biochemists, biophysicists, bacteriologists, pathologists, and radiologists.

Many of our current concepts in the field of shock will undoubtedly be changed and, hopefully, more efficient methods of treatment will be developed as data accumulate from these "shock centers."

Summary

An attempt has been made to document the changing concepts in the field of shock. The beneficial and harmful effects of the homeostatic mechanisms

which occur are discussed. The various factors involved in the "irreversibility" of shock are presented and the methods and treatment, both controversial and proven, are detailed. Finally, there is presented a brief outline of the requirements for a "clinical-research unit."

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The Use of Blood Components In Plasma Volume Replacement

JAMES G. NORMAN, M.D.

THE RAPID DEFINITION of red cell antigen systems since 1945 and the realization of the potential dangers of isoimmunization from transfusions of whole blood have led to a search for more efficient and antigenically less potent substances to restore depleted plasma volume in subjects with oligemic shock. The routine administration of whole blood for this condition is as antiquated as is the "shotgun" prescription.[1]

Despite the maxim that "whole blood replacement is the best treatment for oligemia due to blood loss," I shall endeavor to show that immunologic considerations and the availability of potent plasma volume expanders may render the practice of using whole blood in certain patients open to question.

Before dealing with blood components in detail, I should like to consider certain aspects of oligemic shock in relation to therapy. First, a comment on the word "shock" itself. This grossly overworked and much-abused word, ranking next to "hysterical" in terms of semantic misuse, should be reserved for two situations characterized by disturbed hemodynamics; first, that associated with oligemia and second, that associated with atony of the blood vessels. The importance of the distinction lies in the fact that whereas transfusion is of great value in oligemic states, it is of negligible worth in conditions that may be accompanied by vascular atony viz., pneumonia, gram-negative septicemia, and other severe infections. Similarly it has been shown by Epstein and Relman[2] that transfusion is of no value in the collapse that may accompany coronary occlusion.

The physiology of blood volume depletion has been studied by Howorth and Sharpey-Schafer.[3] A blood loss of 1,500 to 2,000 ml. leads to a fall in right atrial pressure and to a diminished cardiac output—the subject becomes cold and clammy and may display air hunger. A change in central venous pressure reflects change in blood volume and a fall in central venous pressure leads to a fall in cardiac output which in turn leads to a fall in systemic arterial pressure. This produces adrenergic stimulation, an increase in the force of contraction and rate of the heart, constriction of the veins and venules, and regional increase in peripheral resistance chiefly in the skin, muscles, kidney, and gut. The increase in resistance is mainly precapillary so that capillary pressure is reduced and plasma volume is increased at the expense of fluid in the extravascular compartment.

If the inadequate peripheral flow continues, the precapillary resistance loses its sensitivity to adrenergic stimulation while the veins retain their responsiveness so there is a further loss of fluid from the circulation.[4] It follows, therefore, that epinephrine and norepinephrine are contraindicated in the treatment of oligemic shock.

Spontaneous Restoration of Plasma Volume

In the spontaneous restoration of plasma volume, the main limiting factor seems to be the rate at which protein can be added to the plasma. This is evident from the fact that after hemorrhage there is only a slight fall in albumin concentration. Pruitt et al.[5] found that in normal subjects who were bled 10 per cent of their blood volume, the ratio of the plasma volume to albumin in the circulation was 25.7 ml./gm. before bleeding and 26.7 ml./gm. 24 hours later when a volume of approximately 250 ml. had been restored to the circulation.

Acute Loss of Plasma Without Red Cells

In an attempt to restrict this short paper to a consideration of the replacement of plasma volume as distinct from blood volume, I shall discuss a few clinical situations in which plasma loss is predomi-

The Author

● **Dr. Norman, Perth, Western Australia; article submitted as Immunohematologist and Director of Blood Bank, West Virginia University Medical Center, and Assistant Professor of Pathology, W. Va. University, Morgantown.**

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nant. Perhaps the most important of these is acute obstruction of the small intestine. With strangulation of the small bowel, a large volume of blood is often trapped in the obstructed loop. Even in the absence of strangulation, simple obstruction accompanied by distension of the loop leads to a marked fall in plasma volume although the mechanism for this is not well understood. Likewise in crush injuries, there may also be considerable local loss of plasma. In severe burns, there is an almost immediate reduction of plasma volume, due to exudation of plasma into the burned area. Subsequently, there is a further loss which continues for a period of about 24 hours.

The changes in plasma volume following burning produced experimentally, were measured by Keeley et al.[6] Within minutes, a fall in plasma volume amounting to 27 to 36 per cent of the original volume was observed. After this initial fall, a further gradual decrease ensued. It was noted also that plasma protein concentration fell slightly after burning, doubtless due to the entry of protein-free extracellular fluid into the blood stream. As in the acute reduction of blood volume due to hemorrhage, there is an initial phase of compensation. During it the blood pressure may be maintained, though the pulse volume is likely to be poor and the skin cold. After a few hours, the blood pressure falls and the general condition deteriorates. It is very important to begin transfusion at the earliest possible moment, i. e., before the blood pressure has fallen.

Therapeutic Restoration of Plasma Volume

It is evident that a point may be reached in oligemic shock where the red cell mass remaining in the body is so small that only the transfusion of whole blood can restore the patient. A hemoglobin value of less than 94 gm./100 ml. is considered by some to represent this point. However, in treating lesser grades of circulatory depletion, restoration of the plasma volume alone is highly effective. This, as we shall see, can be satisfactorily achieved with the transfusion of blood components, thus lessening the chance of immune reactions to red cell antigens, while at the same time allowing the time necessary to group and type the patient and to perform the obligatory crossmatching tests without which the provision of wholly compatible blood is impossible.

Frozen, Fresh, or Stored Plasma and Serum

As these blood components have now had an established place in resuscitation work for over a quarter of a century, I shall consider them first.

Provided plasma is prepared from small (8 to 20) donor pools, screened for irregular and hemolytic antibodies, and prepared as carefully as possible to exclude antigenic red cell stroma, no immunological requisites need be observed. Frozen and fluid plasma are prepared either from fresh blood or from blood which has been stored for no longer than 26 days after leaving the donor. This ensures that the cationic exchange of intracellular potassium will not have progressed to a point where therapeutically undesirable levels of potassium are present. Sterility checks and storage for six months at 31 C to attenuate the virus of homologous serum hepatitis are mandatory.

Fresh frozen plasma is held to have a more effective concentration of labile coagulation factors (V and VIII in particular) and is not commonly used in the U. S. A. for plasma volume expansion. Serum, used extensively in some British countries, is oncotically effective, and those advocating its use maintain that in intestinal obstruction with ileus it is superior to plasma and that, theoretically at least, it is a more logical source of coagulation factor VII and Christmas factor. Finally, before considering the relative merits of other blood components in oligemic states, it is of interest that Pariera et al[7] produced evidence that fresh plasma is less effective than stored plasma in restoring blood volume, possibly due to the presence of vasoactive substances in the latter.

The value of albumin in the emergency restoration of depleted plasma volume has been long established beyond question. By virtue of its low molecular weight (69,000), albumin exerts 80 per cent of the plasma colloid osmotic pressure.

Heyl et al[8] bled normal male subjects of an amount equal to 10 to 20 per cent of their blood volume in a period of 10 to 15 minutes and then injected 25 per cent albumin. Plasma volume increased by an amount much greater than the volume of solution injected. Thus, on the average, each gram of albumin drew into the circulation 17.4 ml. of extracellular fluid in an hour. Significantly, mild degrees of dehydration did not prevent tissue fluid from being drawn into the blood stream.

Albumin is normally supplied as a "salt-poor" (0.3 gm. per cent) 25 per cent solution representing 12.5 gm. of albumin in 50 ml. volume. This is the osmotic equivalent of 250 ml. of citrated plasma. It can be injected intravenously without any regard to the recipient's antigenic status and the only physiologic requirement is that when clinical or laboratory evidence of dehydration is present, supplementary intravenous fluids, e. g. saline or Ringer's lactate solution, should be given. Unlike other plasma expanders, albumin is effective in the treatment of diseases characterized by severe hypoalbuminemia. Salt-poor serum albumin is unique in this application since other plasma expanders are relatively dilute and contain large amounts of salt. In patients with cirrhosis or nephrosis, serum globulins are usually relatively elevated and albumin can be considered a specific treatment.

There is ordinarily no dosage limit to albumin but large amounts of any fluid lacking in clotting

factors may dilute them in the patient's blood. For this reason, subjects receiving large amounts of albumin following blood loss may subsequently need fresh platelet rich plasma or fresh compatible whole blood, if prothrombin levels are low because of dilution. Albumin does not produce the bleeding tendency seen with synthetic colloids such as dextran, but dilution of available clotting factors may aggravate a bleeding tendency already present. Hardaway et al[9] have shown that in severe oligemic shock, disseminated intravascular coagulation is a prominent feature and results in widespread consumption of clotting factors. The disadvantages of albumin are expense (the current price is between $20 and $30 per unit) and scarcity. Albumin is the best of the presently available blood components and should be the first choice. If it were less expensive and available in sufficient quantity, no other plasma substitute would be required.

As far as the synthetic plasma volume expanders are concerned, dextran is the only synthetic colloid developed in the past 20 years to receive widespread acceptance in the U. S. A. It is a branched polysaccharide made up of glucose units and is normally supplied in this country at an average molecular weight of 70,000. The advantages of dextran outweigh the disadvantages of plasma since it is free from homologous serum hepatitis virus, is inexpensive and is readily available. However, it has several grave disadvantages, the chief of which is its propensity to cause a coagulation defect when given in large amounts. In the blood bank laboratory, it is difficult to provide compatible blood rapidly as the dextran molecule causes pseudoagglutination when matching the patients' serum against the donors' red cells.

This problem is of little moment if the blood sample has been obtained prior to the infusion of dextran but regrettably, if understandably, this precaution often is not observed in the urgent atmosphere of emergency resuscitation and serious delay in obtaining compatible whole blood may ensue if this is not remembered. Neither the bleeding tendency nor the crossmatching problem is usually serious if not more than 1 litre of 6 per cent dextran is given.

Dextran of low molecular weight (40,000) has been the subject of extensive study and is chiefly of interest because dilute solutions tend to reverse erythrocyte "sludging" in the microcirculation in cases of refractory shock, thus promoting capillary blood flow. Low molecular weight dextran does not remain in the circulation as long as standard molecular weight dextran but does effect short term plasma volume expansion. A warning should be sounded about using low molecular weight dextran in oliguric patients or in patients with renal tubular dysfunction. Renal failure, with evidence of tubular epithelial vacuolization ("osmotic nephrosis") has been reported in six separate studies.

Before leaving the subject of plasma volume expanders, I should like to emphasize one further point, and this is the actual volume of fluid administered in oligemic shock is of more importance than the type of fluid used. While agreeing that a normal red cell mass should be maintained, volume in excess of normal should be a fluid other than blood, in order to allow its speedy removal from the circulation after shock is over. It has been shown by Hardaway et al[10] at Walter Reed Hospital, that saline or other intravenous fluid is as effective as is whole blood in increasing blood volume. Although colloid, i. e., human serum albumin, remains in the vascular tree longer than electrolyte fluids, the immediate effect is the same. It has been suggested that part of the beneficial effect of saline infusions in the treatment of circulatory volume depletion is due to the correction of tissue cellular overhydration associated with low plasma sodium produced by hemorrhage[11]; a conclusion based on the work of Brooks et al,[12] who showed that, in dogs rendered severely hypotensive by bleeding, the infusion of hypertonic sodium chloride was lifesaving.

In considering electrolyte fluids, it must be remembered that in severe shock, metabolic acidosis is usually present. Since ordinary saline solutions are slightly acid, Ringer's lactate solution is considered superior in the correction of extravascular fluid deficit.

Shock associated with extensive burns is similar but not identical to that resulting from hemorrhage. The burned area sequesters salt, water, and plasma protein, and this leads to a generalized deficit in extracellular fluid. The condition differs from hemorrhagic shock in that there is less immediate loss of red cell volume and the loss of plasma occurs into the burned area rather than externally. The traditional treatment for burn shock dictated the use of plasma, but recent observations indicate that Ringer's lactate solution may substitute for at least some of the plasma. Moreover, at least one group of investigators has emphasized that in burns, the deficit of mobilizable water and electrolytes may be more important than the deficit in circulating protein. Ringer's lactate solution has been the fluid most commonly advocated to correct burn shock in place of plasma and the successful treatment of burn shock has been reported with Ringer's solution alone.

At this point, I should like to put forward for your consideration, a plan for providing a safe emergency transfusion service based on established immunohematologic concepts.

A suitably monitored blood bank refrigerator, equipped with recording thermograph and warning device, should be installed in the Emergency

Room, Intensive Care Unit, or whatever hospital area is initially concerned with the resuscitation of severely shocked patients. This "ectopic" blood bank would remain under the control of the Hospital Blood Bank for restocking and monitoring purposes. While I do not doubt the ability of surgeons to administer blood, it has been my experience that their ideas of what blood will suffer in terms of thermal insult and mechanical trauma are bizarre in the extreme. Units of whole blood, Group O Rh-negative, carefully screened for irregular antibodies and immune hemolysins of the ABO system, should be hung upside down, i. e., with the entry ports downwards. Thus the red cells will sediment and can be given independently of the supernatant plasma if the patient's plasma volume has been restored by adequate replacement therapy.

However, if the donor population is large enough to maintain a daily stock of 2 to 4 units of Group O Rh-negative blood of acceptable criteria as regards antibodies, there is no need to carry out red cell sedimentation unless the administration of accompanying plasma is contraindicated by circulatory overloading. Here, I must emphasize that I am not advocating the use of uncrossmatched blood except in circumstances (and they occur only rarely if ever) where any delay, however short, will jeopardize the patient's life. Even if the decision is made to undertake the transfusion of whole blood without preliminary crossmatching, a sample of blood must be obtained from the patient before any intravenous therapy is commenced.

This will enable the Blood Bank staff to provide group and type-specific blood to restore the normal red cell mass after emergency correction to a normovolemic state.

The only theoretical objection to giving Rh-negative red cells is where the recipient may lack the hr'(c) antigen and such a person may be immunized by the administration of cde/cde blood. Despite the fact that hr'(c) ranks second only to D in terms of antigenicity within the Rhesus System, no one would seriously suggest that a decision not to use hr'(c) positive red cells would be made in a life-threatening situation. However, I would advocate that where this antigenic disparity is shown to exist, follow-up screening of the recipients' serum be carried out at two and six months to detect isoimmunization. Twenty-five per cent human serum albumin, plasma, Ringer's lactate solution, and dextran should be stored adjacent to the blood refrigerator and stocks checked periodically by the Blood Bank staff and replenished as necessary.

In conclusion, the principles discussed in this paper for the resuscitation of patients suffering from oligemic shock may be summarized as follows:

1. A plea is made to discard the outmoded concept that whole blood be arbitrarily given to such patients irrespective of the total red cell mass as determined by volumetric studies.

2. The most urgent need in shocked patients is restoration of circulating plasma volume, and the timely administration of 25 per cent albumin, together with the supplementary use of Ringer's lactate solution to correct the metabolic acidosis that occurs with severe oligemia, will intelligently deal with the situation. Low molecular weight dextran, in volume no greater than 1,000 ml., is of established value in correcting capillary stasis and promoting normal urinary output.

3. Where there is obvious need to augment as speedily as possible the oxygen carrying capacity of the blood in subjects with massive whole blood loss, the giving of either sedimented cells or whole blood of Group O type Rh-negative that has been previously screened for irregular antibodies and immune hemolysins, is recommended.

4. The collection of a sample of the patient's blood for accurate grouping and typing before blood or a colloid plasma volume expander is given should be mandatory.

5. A scheme is described for establishing and maintaining a Blood Bank Unit in the appropriate hospital area concerned with resuscitation. Stocking, and supervising the storage of blood and blood components, remain properly the province of the Blood Bank Staff.

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Exchange Transfusion
A Safe Procedure for Most Newborns

DONALD J. FRANK, M.D., and ROSARIO MIRAFLOR, M.D.

IN SPITE OF REFINEMENTS in technic and improved anticipatory care, exchange transfusion mortality data are still frequently misinterpreted and, consciously or unconsciously, are used as one of many criteria to determine the necessity of the procedure in the day-to-day practice of pediatrics.

During the past 17 years, many refinements in exchange transfusion technic have been developed and potential hazards bypassed. Odell, Bryan, and Richmond's classification of these potential hazards is fairly complete, and includes the following: vascular, cardiac, electrolyte, clotting, infection, and a miscellaneous group.[1] Many other reports have emphasized the association of exchange transfusion mortality with inexperienced personnel. Fortunately, this era is over. Today, most pediatric house officers have more than ample experience in exchange transfusion technics before they complete their training. Recently, Lucey, Randall, and Murray reported hypoglycemia in three infants with erythroblastosis fetalis,[2] and Driscoll reported elevated insulin levels in pancreata of autopsied infants with this disease.[3] These findings may make it necessary to add hypoglycemia to the list of potential hazards.

The purpose of this report is to reinforce the concept that exchange transfusion mortality today is negligible in all newborns except those with severe hemolytic disease. To do this, a review of all exchange transfusions completed at Good Samaritan Hospital during 1964 and 1965 was carried out.

Seventy-two infants with Rh disease were exchange transfused 150 times; 46 jaundiced infants with nonspecific hyperbilirubinemia received 52 exchange transfusions; 34 infants with major blood type incompatibilities received 45 exchange transfusions (Table 1).

TABLE 1. *Exchange Transfusions Good Samaritan Hospital 1964 - 1965*

Cause of Jaundice	No. of Infants	No. of Exchange
Rh	72	150
ABO	34	45
Non-specific	46	52
Total	152	247

From the Department of Pediatrics of the Good Samaritan Hospital and the Department of Pediatrics of the University of Cincinnati College of Medicine. Submitted December 12, 1967.

The Authors

● **Dr. Frank, Cincinnati, is Assistant Professor of Pediatrics, The University of Cincinnati College of Medicine; Director Pediatric Division, Good Samaritan Hospital.**

● **Dr. Miraflor, Cincinnati, is Resident in Pediatrics, Good Samaritan Hospital.**

Premature infants without hemolytic disease were exchanged when the indirect bilirubin level exceeded 18 mg./100 ml. Term infants without hemolytic disease were exchanged when the indirect bilirubin level exceeded 25 mg./100 ml. Rh and ABO infants without severe disease were exchanged when indirect bilirubin levels exceeded 20 mg./100 ml. The amount and rate of rise of indirect bilirubin, rather than an "exchange level," along with other standard laboratory and clinical data, were used as criteria for exchange in infants with severe hemolytic disease.

The technic of exchange transfusion was that described by Allen and Diamond.[4] Sterile disposable exchange transfusion sets* were used in all instances. Smaller premature infants and all other high-risk infants were exchanged in Isolettes.®** A TC-10 Telecor® cardiac monitor† was used during all procedures. All exchange transfusions were done through the umbilical vein. Blood used for all exchange transfusions was less than 48 hours old. Acid citrate dextrose (A. C. D.) solution†† was used as the anticoagulant in all instances. During the latter half of the period reviewed, blood was warmed by passing it through a polyethylene coil‡ immersed in a 37° F water bath prior to entry into the exchange apparatus. The time to complete a two volume ex-

* Pharmaseal Laboratories
Glendale, California

** Air-Shields, Inc.
Hatboro, Pennsylvania

† Burdick Corporation
Milton, Wisconsin

†† Fenwal Laboratories
Morton Grove, Illinois

‡ Abbott Laboratories
North Chicago, Illinois

change in all infants ranged from 40 to 90 minutes. Only experienced pediatricians or pediatric house staff, under supervision, performed the procedures.

Results

Boggs and Westphal[5] suggested that an arbitrary time limit following an exchange transfusion be chosen, and that it be agreed that all deaths occurring within this time limit be considered as deaths resulting from the procedure. He chose the arbitrary time limit of six hours. For uniformity, a similar time limit was used in this review, realizing full well that infant deaths hours after the completion of the procedure may in no way have a cause and effect relationship.

Of the 72 infants with Rh disease who received exchange transfusions, there were seven deaths. The mortality rate per infant in this group was 9.6 per cent. The mortality rate in this group per exchange tranfusion was 4.7 per cent (Table 2). All infants who died had severe Rh disease. Four of the seven had obvious clinical signs of hydrops fetalis. One moribund infant died at the end of the procedure; the other six died within the six hour limit. All infants who died were premature by gestation, if not by weight. The presence of edema in most of these infants made interpretation of prematurity by weight impossible. Using the Colorado Intrauterine Growth

TABLE 2. *Exchange Transfusion Deaths During or Within Six Hours of the Procedure*

Cause of Jaundice	No. of Deaths	Mort. Rate per Infant	Mort. Rate per Exch.
Rh	7	9.6%	4.7%
ABO	0	0	0
Non Specific	0	0	0

Charts,[9] six of the seven infants were over the 50th percentile for weight and three were over the 90th percentile. For this reason, earlier reports of differences in exchange transfusion mortality between "premature" and "term" infants do not appear to be valid if weight, and not gestation, is used to separate the two groups (Table 3). Five of the seven infants were autopsied and demonstrated pathologic findings typical of erythroblastosis fetalis. In addition, one infant had hyaline membrane disease, and another, extensive pneumonia. No other visceral anomalies or significant disease unrelated to the primary disease were present in any of the autopsied infants.

Cardiac arrhythmias were noted clinically during exchange transfusion in all seven infants who died. Van Praagh[6] reported that a clinical diagnosis of cardiac arrhythmia was made in 13 of 25 infants who died during, or soon after, exchange transfusion. More recently, Van der Hanwaert et al[7] reported

TABLE 3. *Weight, Gestation, and Weight Percentile of Seven Rh Infants Who Died During or Within Six Hours of Exchange*

Infant	Weight in Grams	Gest. In Weeks	Percentile
Ko	1400	31	50th
Hu	1800	32	50th-75th
St	1800	30	> 90th
Ru	2700	36	25th-50th
Ha	2730	34	> 90th
Qu	2948	36	75th
Gr	2950	32	> 90th

TABLE 4. *Six Hour Mortality of Exchange Transfusion. All Indications (Rh, ABO, Nonspecific Hyperbilirubinemia).*

	Mort. per Inf.	Mort. per Exch.
Diamond	7.4%	6.7%
Boggs & Westphal	3.2%	1.9%
Frank & Miraflor	4.7%	2.8%

myocardial infarction as the cause of death in an infant with severe hemolytic disease who became apneic during an exchange transfusion and died 12 hours later. This diagnosis would not have been suspected without electrocardiographic monitoring during the procedure. Bajpai et al[8] recently demonstrated electrocardiographic changes in infants undergoing exchange transfusion with citrated blood. The changes were attributed to hypomagnesemia; since magnesium, like calcium, is a divalent cation known to bind with citrate. These reports, coupled with our experience, point up the need for wider use of electrocardiography in detecting cardiac arrhythmias during exchange transfusion.

There were no deaths in the 34 infants with ABO incompatibility, who received 45 exchange transfusions. There were no deaths in the 46 infants with nonspecific hyperbilirubinemia, who received 52 exchange transfusions (Table 2). In addition, none of the infants in either of these groups developed significant cardiac arrhythmias or other complications that could be attributed to the procedure. The findings in these two groups were similar to those reported by Boggs and Westphal.[5] They reported two deaths among 132 infants, who were exchanged 209 times, and no deaths among 81 infants with nonspecific hyperbilirubinemia, who were exchanged 122 times. The total exchange transfusion mortality (Rh, ABO, nonspecific) in this study (as shown in Table 4) was slightly greater than that reported by Boggs and Westphal,[5] and somewhat less than that reported by Diamond.[10]

Conclusion

All infant deaths in this review of 247 exchange transfusions were associated with severe hemolytic disease. In such infants, it is virtually impossible

to say, with certainty, whether death was primarily related to the disease or to the procedure.

Aidin et al [11] and Zuelzer and Mudgett,[12] in 1950, were among the first to draw attention to the fact that kernicterus could occur in jaundiced premature infants not diagnosed as having hemolytic disease. The association of kernicterus in jaundiced nonsensitized full term infants is less well documented, but it is still a constant source of concern for those caring for such infants.

The authors are not so naive as to believe that unexpected exchange transfusion deaths do not occur in jaundiced infants. We do believe, however, that with proper precautions, and respect for the procedure, mortality is negligible in all but those with severe hemolytic disease. Risks associated with the procedure should not be high on the list of reasons why a particular infant should, or should not, be exchanged.

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THE YOUNG HYPERTENSIVE. — Breckenridge and his colleagues point out the moral: that youth alone is an insufficient recommendation for extensive investigation, especially aortography, in the hypertensive patient. Since by far the commonest renal lesion in these young hypertensive patients was chronic pyelonephritis, which could usually be diagnosed by the intravenous pyelogram and by examination of the urine, it seems that aortography or divided function studies can be therapeutically justified only under special circumstances. Patients suitable for intensive investigation are those with a loud renal artery bruit to whom surgery can be offered and by whom it might be accepted, and possibly also those who prove unduly resistant to drug therapy, those who find drug side-effects intolerable, or those whose occupation or domicile makes adequate supervision of their therapy impossible.

Young hypertensive patients should certainly not be denied the benefits of intravenous pyelography, urinalysis, screening of blood electrolytes to detect primary hyperaldosteronism, and, if possible, screening of the urine to detect phaeochromocytoma. These tests are simple, safe, and reasonably inexpensive in time and money. Except under special circumstances investigation should stop at this point, and the patient should be treated with hypotensive drugs unless the reasons for proceeding further are unusually compelling. — Leading Article, *British Medical Journal*, 4:569, December 9, 1967.

Peripheral Vascular Disease

VII. Arteriospastic Diseases

RAY W. GIFFORD, JR., M.D.

THREE DISORDERS of the peripheral circulation are characterized by spasm of small cutaneous arteries and arterioles and are manifested by changes in the color of the skin. Usually the patients are women between the ages of 20 and 50 years. More than one of these diseases can be present in the same patient.

(1) **Acrocyanosis,** the least common and least serious of the three arteriospastic diseases, presents as persistent cyanosis of the hands and feet. Superficially, this condition might be confused with cyanotic congenital heart disease, except that arterial oxygen saturation is normal; cardiac murmurs and clubbing of the fingers are absent; and cyanosis is confined to the hands and to the feet. There are no sinister implications to this harmless disorder, and ulceration and gangrene do not occur. The only treatment necessary is to reassure the apprehensive patient and, occasionally, to administer a vasodilating agent such as phenoxybenzamine (Dibenzylene®) 10 mg., three times daily, when the discoloration is a source of embarrassment.

(2) **Livedo reticularis** is characterized by cyanosis that is distributed in a fishnet or lacelike pattern on the hands, feet, extremities, and sometimes on the trunk, especially on the buttocks. Except in mild cases, the cyanosis is present constantly, although it is more prominent when the patient is cold. Occasionally the vasospasm will lead to ischemic ulceration on the lower legs near the malleoli or on the toes. Sometimes livedo reticularis is associated with and may be the first manifestation of a systemic disease such as lupus erythematosus, periarteritis nodosa, or cryoglobulinemia. Showers of microemboli from an atheromatous aorta may cause livedo reticularis and ischemic ulcerations of the feet. Usually, livedo reticularis occurs in the absence of underlying disease, and is designated as "primary" to distinguish it from "symptomatic" or "secondary" livedo reticularis. When livedo reticularis is secondary, treatment should be directed at the underlying disease. Treatment of primary livedo reticularis is usually not necessary unless the condition is severe and ulcerations occur, in which case administration of vasodilating drugs or sympathectomy is helpful.

(3) **Raynaud's phenomenon** is characterized by short episodes (less than ten minutes) of pallor or cyanosis, or both, usually confined to one or more digits. The fingers are more likely to be affected than the toes. Changes of skin color are frequently precipitated by exposure to cold and occasionally by emotional reactions. Often, Raynaud's phenomenon is a symptom or manifestation of another disease, such as rheumatoid arthritis, scleroderma, lupus erythematosus, arteriosclerosis obliterans, or thromboangiitis obliterans. When only one hand is affected, chronic occupational trauma or thoracic-outlet syndrome should be considered. Rarely, Raynaud's phenomenon is a manifestation of lead, arsenic, or ergot intoxication; occasionally it is a manifestation of some diseases of the central or peripheral nervous system. Sometimes Raynaud's phenomenon is the first clinical manifestation of these diseases. Raynaud's phenomenon may be a late result of trench foot, immersion foot, or frostbite. When Raynaud's phenomenon has been present for at least two years in the absence of underlying disease to which it might be secondary, it is properly called primary Raynaud's phenomenon or Raynaud's disease. When the physician is certain that he is dealing with Raynaud's disease (not with secondary Raynaud's phenomenon), he can assure the patient that the prognosis is good. Major amputations are never necessary, and phalangeal amputations are required in less than one per cent of cases. Painful ulcerations at the tips of the digits or sclerodermatous changes confined to the digits, or both, occur in about 30 per cent of patients with Raynaud's disease, but these complications usually do not lead to prolonged disability. When Raynaud's disease is not so severe as to require surgical treatment, approximately 50 per cent of patients will experience spontaneous improvement or even disappearance of Raynaud's phenomenon. In mild cases, protection of the extremities from thermal, chemical, and mechanical trauma is the only treatment needed. In severe cases a vasodilating drug, such as phenoxybenzamine (Dibenzylene®) or cyclandelate (Cyclospasmol®), should be prescribed, and an emollient, such as toilet lanolin, should be applied to the hands or feet, or both, twice daily. In approximately 20 per cent of patients, symptoms cannot be controlled with medical treatment, and sympathectomy is indicated. Sympathectomy is of little or no value for secondary Raynaud's phenomenon.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio.

Maternal Deaths Involving Ruptured Ectopic Pregnancies*

By the OSMA COMMITTEE ON MATERNAL HEALTH**

With Comment of Consulting Obstetrician and Gynecologist

IN THE Maternal Mortality Report for Ohio, "A 10-Year Survey, 1955-1964," published in June, 1967, *ectopic pregnancy* continues to be of great significance as a primary cause of maternal death. Forty of the 206 maternal deaths from hemorrhage (19.4 per cent) resulted from ectopic pregnancy; well over half of these patients were never operated upon! They died *undelivered*. The following three cases serve to illustrate the frustrations and difficulties encountered with this condition.*

Generally, the body of the deceased is submitted to the Coroner for investigation concerning the cause of death. Records thereafter available are accurate and concise, but they *omit* details in the *past history* of the deceased.

Case No. 636

This patient was a 34 year old colored woman, parity unknown, who died undelivered. Shortly after arriving at work she experienced a sudden, severe, lower abdominal pain — was placed on a couch and died. She was pronounced dead at the place of her employment. There was no other history available; her husband reported that his wife was apparently well before she departed for her domestic job in the morning.

At autopsy the peritoneal cavity contained 1,500 ml. of clotted blood, together with a 4 cm. fetus of 7 to 8 weeks' gestation. The right tube and ovary were fused together; the fimbria was patent. Just distal to the isthmus the tube was dilated to a diameter of 2.8 cm.; the stump of the umbilical cord protruded through a large defect in the swollen segment of the tube.

Cause of Death (Coroner's Autopsy): (1) Massive intraperitoneal hemorrhage due to ruptured ectopic pregnancy; (2) Healed salpingo-oophoritis; (3) Uterine leiomyomata; (4) Adenomyosis of uterus.

Comment

The Committee felt that there must have been symptoms present in this patient which should have caused her to seek medical help; yet, these and other details were lacking. With regret, members discussed the meager information available; by a narrow margin the Committee eventually voted this a preventable maternal death. This case represents the tragic course of many ectopic pregnancies, e. g., unexpected collapse and sudden death, before the patient reaches the hospital.

Case No. 802

This was a 40 year old colored woman, parity unknown, who died undelivered. Details of her past history were not recorded. At 1:45 A. M., January 17, she was brought to the emergency room of the hospital by her husband; she was in profound shock. A diagnosis of possible myocardial infarction was entertained; the pulse rate was 120 per minute, blood pressure 0/0 to 65/40, and the patient could not speak. The extent and details of the examination performed upon the patient were not recorded. The record did *not note* a pelvic examination. However, the husband did state that she had had a "cold" for three weeks; she had consulted her family physician on January 10.

Prior to admission, January 17, the patient complained of vertigo, syncope and she perspired profusely. Personnel in the emergency room January 17, noted that there was not time to carry out tests other than blood alcohol. In spite of therapy (Coramine®, 1 ampule, followed by elevation of the blood pressure to 65/40), the patient pursued a progressive downhill clinical course and died at 2:50 A. M., 65 minutes after entering the emergency room.

Cause of Death (Coroner's Autopsy): (1) Ectopic pregnancy of right oviduct with rupture and hemoperitoneum (2,400 cc.); (2) Decidual reaction of the endometrium; (3) Corpora lutea of ovaries, bilateral.

Comment

The Committee studied available facts in the case with interest, again regretting that many conclusive details were omitted. The extent and findings elicited upon examination of the patient by her physician January 10, and by the house staff in the emergency room on January 17, were considered *very* important! Members agreed that at age 40, the suspicion of an existing ectopic pregnancy would be less than if the patient were in a younger age bracket. However, the importance of a *routine* pelvic examination in all female patients was emphasized. The Committee voted this a preventable maternal death.

Case No. 785

The patient was a 20 year old colored woman, parity not known. She was a known prostitute. The past medical history was very meager. According to police she had been drinking the night before, July 7, and went to a friend's home. The deceased remained there until the following evening because of "stomach pains." She was found dead in bed at 7 A. M., July 8.

Cause of Death (Autopsy): (1) Intraabdominal hemorrhage secondary to rupture of ectopic (tubal) pregnancy. There was present an adherent mass involving the right

**A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

tube and ovary. The mass had a smooth glistening surface and exhibited many areas of hemorrhage throughout the structure with *rupture* of the posterior wall. It contained a male fetus, 10 cm. in length.

Comment

Again the Committee, somewhat puzzled by a lack of detailed information, felt there was enough organic disease present for the patient to have sought medical consultation earlier. Members commented, wondering why more ectopic pregnancies were not observed in prostitutes because of the linkage with recurrent pelvic infection.

In this case the patients obviously had suffered important symptoms the night before she was found dead. The real importance of a complete examination by autopsy is brilliantly portrayed in this case. Members wondered if this was a "Coroner's Case." In final deliberation, the Committee voted this a preventable maternal death.

Comment of Consultant

The following comment of a consultant specializing in obstetrics and gynecology was given at the request of The Committee.

Any female capable of reproduction is capable of extrauterine implantation. It is not enough to suspect only susceptible people. It can happen to anyone!

The reported cases show the terrifying outcome of full-blown and progressive disease. We can only guess at the number who fortunately resolve their ectopics short of this catastrophe. Occult early expulsion from the tube or a "clinically smaller bleed," must often go by unnoticed as any of a number of other diagnoses.

It may be well to have asked someone *outside* the specialty to comment on the patients described. Much as it is difficult for the gynecologist to keep his perspective broad when discussing low back pain or amenorrhea, so must another less in tune with this disease work to remember its mimicry and lethal potential. Since this is a rapid killer, we probably should all be sensitized equally, as well! In truth, there are very few reasons why women in the reproductive years suddenly go into shock.

These cases were uncomfortably classified as preventable maternal deaths. We would agree that it seems difficult to acknowledge that this bizarre reproductive accident could be anything but preventable. Yet the ectopic pregnancy is a sleeping tiger for this very reason. The symptomatic triviality of the *early* developing problem gives no hint of its *fatal* potential.

Awareness is our *only* effective tool and "routine gynecologic examination" is the vehicle, possibly only because it initiates relative thinking. Once the idea is there — proof or disproof must follow in logical sequence.

Regard for trivial symptoms is a wide variable among patients and physicians. Being "a few days late" or noting "some lower abdominal soreness" might well be interpreted as evidence of a patient's good insight into everyday occurrences. Yet these complaints are commonplace in the retrospective stories concerning more ectopic pregnancies. This is a disease often not preceeded by enough time to arouse great suspicion and it remains our challenge to hear, judge and conclude on this often meager basis — to hopefully *obviate* situations as described in the case reports, listed above.

The classic ectopic (usually tubal) pregnancy is well-described. Unilateral pelvic-abdominal pain and vaginal bleeding following a missed menstrual period by about two weeks is a red flag! A significant para-uterine mass all but confirms the diagnosis. Hospitalization with reexamination under anesthesia, culdocentesis, culdotomy or culdoscopy and laparotomy (if indicated) concludes the problem. Patients who show shock in addition, require anti-shock treatment prior to their procedures. Available *whole blood* and *time* become involved as significant therapeutic factors.

The ectopic pregnancy often mimics closely, various other less malignant clinical situations. The early threatened abortion with its attendant corpus luteum of pregnancy, a bleeding, persistent follicular cyst or the hemorrhagic functional corpus luteum are all frequent gynecologic "act-alikes." Expectant cure is considered good judgment for all except the ectopic gestation where acute diagnostic intervention provides our only safeguard!

The pure science of extrauterine pregnancy sets its occurrence at one per 200 to 300 livebirths. (A fairly startling statistic as we regard frequency of disease which can kill acutely). It occurs more often in women with altered tubo-ovarian function where the zygote either by delay or entrapment implants short of the endometrial cavity. Physiologically, the rapidly burrowing trophoblast soon *outstrips* its blood supply and the capacity of its flimsy container to confine it. Until then however, trophoblastic hormones exert their effect in the usual manner — to decidualize the receptive uterus, tubes and ovaries. The fate of such an implanation now becomes a product of many things. As suggested, spontaneous evacuation through the distal tube with minimal bleeding and symptoms, may occur more often than we think. Access to other sites for implantation or acquisition of additional blood supply from adjacent viscera may perpetuate the pregnancy longer than the classic time relationships. In any event, the critical value lies in function of the tenuous blood supply whose integrity must persist for maintenance. Acute and massive intraperitoneal bleeding with physiologic and neurogenic shock characterize the cases of maternal loss or near loss.

The significance of "trivial" complaints in the progress of this disease cannot be overemphasized! Detection of an ectopic pregnancy in its early phases is very difficult, yet we must conclude that *suspicion* and early diagnosis provide the only method for preventing the often-lethal acute hemorrhage.



NEWS AND Organization Section

Private Practice in the Future

By ROBERT E. TSCHANTZ, M.D.

As physicians and as citizens of this nation, it is easy to become lost in the rapid daily crises of our time. As a result, the future often becomes obscured.

The busy physician is well aware that the basic struggle going on in America today is between those social planners who truly believe that government must solve our problems and those citizens that just as firmly believe that it has been the happy combination of individual enterprise, plus individual responsibility that made our nation great.

The social planners reluctantly admit the latter, but in their irrational thinking argue that the problems of the future can be solved only by central government control.

The health-oriented 89th Congress had an avalanche of 1,600 health bills of which 43 became laws. This is a good indication that the "big government" planners are winning.

False Paternalistic Conviction

As an American Medical Association spokesman pointed out in Washington recently, the trouble with the government approach is that welfarism requires false paternalistic conviction that the state knows better than the individual what is good for the individual.

This same false social planning battens on paralyzing taxes thereby reducing the taxpayer's disposable income in order to save him, these planners contend, from the error of using his income unwisely.

They argue that if you compel a man to pay taxes to finance a national health scheme you reduce the likelihood that he will spend his money on gin, horses, or other less economically productive wants.

Their theory is that the taxpayers are better for it.

But they don't tell you that their false "soak the rich" theory is a hoax. If our government confiscated all taxable incomes over $25 thousand, this would produce only $2.1 billion in taxes. In 1967, the Federal government spent, on health programs alone, $16,450,000,000.

The social planners are well-intentioned. But the road to hell is paved with good intentions, and the welfarists of this country have already paved several miles of it as a superhighway.

Bankruptcy in Billions

Their Title 19 program for the fiscal year ending June 30, 1968, was bankrupt March 31. HEW wants $1,135,000,000 just to finance the Federal share of Title 19 for April, May, and June.

And the welfarists want to go right on with their paving.

One of many troubles with welfarism is that once it gets into a nation's bloodstream it becomes self-generating, a malignant disease that induces a growing financial and psychological leukemia.

The disease creates a parasitic citizenry, a loss of human appetite for individual freedom, an amnesia about the past—a past of relationship between and respect for work and reward.

*Dr. Tschantz, of Canton, is a Past President of the Ohio State Medical Association, and member of the OSMA Committee on Government Medical Care Programs. This article is the text of his script prepared for presentation as part of a panel discussion on "Government Medical Care Programs and OSMA Policy," a feature of the OSMA Annual Meeting, Cincinnati, May 15, 1968.

And above all, the welfare state creates in the individual a morbid overwhelming preoccupation with security. In the welfare state opportunity is a dirty word.

Look at our Social Security.

Social Security in America is a system of enforced poverty. If a retired American has the need and the initiative to augment his income, he is penalized by his government in that his Social Security check is reduced accordingly.

No longer can there be any question that the bureaucratic welfarists, in and outside of government, plan the complete destruction of the private sector of American medicine.

You heard here the well-documented resumes of major government programs already in effect, the broad outline of the welfarists' methods and controls.

It is tragic that the lessons of the past—the warning signs of the present, the failures in those countries where medicine is socialized—without a doubt are to be **completely disregarded** by our national leaders in the Congress and in the executive branch of government; **disregarded** by certain labor leaders, by our national news media, by National Blue Cross, by hospital administrators, by our medical educators, by the very wage earners and their families who will suffer the most under socialism.

Tragic Paradox

It is ironic that private enterprise is not only financing socialism in most of the so-called free world, but it also is financing socialism in America.

For many years the medical profession has been accurately forecasting medicine's future if government intervened in medicine: The passage of all the various government health programs; the direction of the demands of labor leaders; the trend of voluntary health insurance toward involuntary fees; the brinksmanship of many hospitals and medical schools in flirting, and outright courting federal dictation.

All make it possible to venture a highly educated guess as to what the future of medicine will be if you physicians do not become directly, actively, and forcefully involved.

At this point, I am reminded of the minister who reputedly had the ability to foretell the future.

One Sunday, depressed with the world, he told his congregation: "I have looked into the future and I can honestly say, **It won't work!**"

If that present trend continues, I am in complete agreement with that minister.

Two Per Cent—A 'National Demand'

Consider briefly some of the forces in medicine's future:

The predominent force is that 98 per cent of our patients—**ninety-eight per cent**—still prefer their own personal physician.

Only two per cent—yes, two per cent and not a democratic majority or national demand by the wildest imagination -of America's population prefer consumer-controlled group medical care, such as the Kaiser Permanente system.

Woefully, sadly I would even say immorally—we physicians providing the professional care wanted by 98 per cent of our patients **are** by forfeit, by disinterest, by our own neglect, permitting the future of our profession to be shaped by the forces that control two per cent of the nation's medical service.

Planning It—For Medicine

Further, these are not medical forces. They are lay forces that control these medical panels.

In 1959 in Pittsburgh at the AMA's first prepayment meeting for medical societies, insurance carriers and labor unions—Isidore Falk, real architect of Medicare, as a labor spokesman at that 1959 meeting —clearly outlined labor's idea of the future of medicine.

Falk at that time was spouting arguments for the C.I.O. to use in labor's false assumption that prepaid, consumer-controlled group practice assures medical superiority.

Of course, Falk favors this type of practice over fee for service, and he used the same debatable figures in 1959 that are being used by opponents of private practice today.

It is interesting, and tragically significant, that Isidore Falk is no longer working for labor, but is now **teaching** at the Yale Medical School, as a full professor in the Department of Epidemiology and Public Health.

Falk has had a major role in the fashioning of many national and international conferences and plans for socialized medicine. He has worked toward this goal since the early 1920's.

Consumer-Controlled Medicine

Another union participant in that 1959 conference, Jerome Pollack and equal to Falk in advocating consumer-controlled medicine, is now teaching at Harvard Medical School.

At this 1959 conference medical profession representatives were told by a profane, table-pounding labor spokesman that **regardless** of what physicians felt about how medicine should be practiced; **regardless** of our many approaches to voluntary methods of financing health care; **regardless** of our personal freedom and independence; very shortly, this spokesman claimed, all physicians would be practicing under a prepaid, consumer-controlled group practice.

His words and threats were seemingly prophetic. How are they being brought about? Consider these facts:

Serious pressures are being brought on physicians by third parties and medical education committees—

pressures to bring physicians' offices into the hospital, pressures to make physicians salaried employees of the hospitals and, ultimately, government employees.

Your Taxes—To Fight You

Such a tragedy would bring the privately practicing physician to his knees.

It would lead to a rapid downfall of the finest medical care system known to man.

The attack on this system is well under way.

It is a fierce campaign.

It is well planned.

It is tremendously financed **through the use of millions of federal tax dollars.**

A full enlightenment, dedicated counterattack—and only enlightenment and counterattack by **all members** of our medical profession—is the only solution.

We must withstand the heavy pressures of government agencies and bureaucrats.

We must combat the well-coordinated and consistent diatribes of key labor leaders.

We must reverse the increasing number of physician-employees of hospitals.

We must curtail group practice by medical schools.

We must insist—gentlemen, we must **demand**—that medical educators devote more curriculum to medical ethics and the art of medicine.

I am convinced that it is only the desire of too many physicians to work a 40-hour week that is leading to the successful promotion of group practice in the hospitals, in our medical schools, in government, and among consumer interests.

All these forces are at work to ultimately force physicians out of the private, independent, practice of medicine, thereby reducing them to vassals of the federal bureaucrats.

Control Through Hospitals

How can our medical care system be changed? Aneurin Bevin, when prime minister of Britain, gave us the answer.

When asked how he would control the British doctor, he simply stated that he would not attempt to directly control the doctor. All he had to do was control the hospitals. Control of the American physician lies directly with control of America's hospitals.

Americans are, with nauseating repetition, told that controls of health care must be instituted because of rapidly rising health care costs.

The British experience with their national health service proves, if proof is needed, that welfare for the sake of welfare courts bankruptcy, erodes quality, aggravates imbalance between supply and demand, and throttles progress.

It is significant that the private physician's share of the health dollar was 29 cents in 1950 and 28 cents in 1965.

In contrast, between 1949 and 1968 the annual Social Security tax rose from $30 to $343.20, an increase of 1,100 per cent.

Is it not strange that we do not hear the same expressions of concern about this fiasco that we hear about rising health care costs?

Physicians and medical societies **must** meet these challenges more effectively than we have in the past.

Meeting Challenges

We must challenge public statements that do not ring true.

We must apply, equally and forcefully, the *Principles of Medical Ethics,* whether it be a matter of fees or of conduct.

We must spend more time warning our patients that they, not we, will be the losers under government medicine.

If we are to continue as a noble profession, living by a self-imposed code of ethics is an absolute necessity.

On the other hand, it behooves **all** other parties that berate our profession, whether they be social planners, labor leaders, hospital management, the health insurance industry, or government officials, to make very certain that they have created and are following a code of ethics as moral as ours.

I believe that the vast majority of physicians, and the so-called social economists, have been too preoccupied with costs.

There has been almost psychopathic lack of political recognition that this is a period of heavy inflation, and medicine is **following**, not leading the inflationary spiral.

We in private practice can keep pace with these changing times.

At the same time, we can continue to provide quality medical care.

Bureaucrats in government, regardless of what we do or say will try to destroy us under the federally subsidized campaign they have waged for so many years.

Government Costs—Highest

They are not concerned with quality or cost. It makes no difference to them that the cost of medical care in a government agency such as the Veterans Administration is probably the highest in the nation.

You never hear them report, or even admit that another federal program, health care for the Ameri-

can Indian, is probably the poorest as far as quality is concerned.

As our State Association President, Dr. Robert Howard, said recently, Medicare and Medicaid are just as the AMA predicted, inflationary, compulsive, and bankrupt.

Do you know that on March 11, 1968, H.R. 15399 was introduced in Congress because Title 19 was bankrupt and needed $1,135,000,000 to meet Federal obligations to the states for April 1 to June 30.

This means that the budgetary estimates prepared by Mr. Wilbur Cohen and company for Title 19 were **25 per cent below costs.**

And this is a program that we physicians are subsidizing through reduced fees or no fees to the tune of untold millions of dollars with absolutely no public credit.

Passing the Blame

But the proponents of federal health programs have conveniently forgotten our warnings about the dangerous, inflationary side effects of their measures.

Instead of admitting their own false assumptions, their misleading statements, their false statistics, they blame medicine for rising costs.

They set up these free-for-all programs, then express amazement because of a high utilization rate. When a physician attempts to reduce utilization, such as Dr. Overstreet did in Toledo, he is publicly slandered by the politicians and the labor press while Social Security's top officials remain sickingly quiet.

We are constantly harangued about the so-called "shortage of physicians."

It is true that we must produce more practicing physicians. Medicine, through the AMA, has been encouraging this for many years.

However, medical schools are not started or enlarged over night.

Doctors Where They Are Needed

It behooves government officials, hospitals, and medical educators to cut the red tape and release for patient care the thousands of physicians in nonmedical or nonpracticing positions.

It behooves our profession to insist that these physicians do that for which they were trained—care for patients—rather than count paper clips.

It behooves medical schools to return to their original mission—the education of the doctor of medicine—and to halt immediately their constant clamoring for federal research funds and research-oriented faculties.

It behooves the Joint Commission on Accreditation of Hospitals to return to its original purpose—an evaluation of the quality of patient care—rather than its present harpings on social philosophy.

The time and effort thousands of physicians must give toward keeping medicine independent of bureaucrat shackles could better be spent in caring for sick persons if only the social planners would somehow spend their energies toward eliminating need among the needy rather than touting programs that make the needy totally dependent on government.

This is the age of preventive medicine. It is high time some of these preventive ideas were adopted by these social planners rather than their continual insistence on solving American problems—not the American way, **but, rather** using old world ideas that bring **old world failures** to these shores.

Turn of Medical Education

It is highly indicative that the full results of the struggle between Sir William Osler and Dr. William S. Halsted over how medical students should be taught are just now being fully tabulated.

As you may recall, Dr. Osler believed medical students could best be taught by men **in the active practice of medicine.**

Dr. Halsted contended that only full-time teachers should instruct medical students.

It is a great tragedy that Sir William lost and Dr. Halsted won this battle. As a result, Dr. Osler left John Hopkins and was denied the opportunity to fashion American medical education along realistic lines.

No one can doubt that American medical schools have turned out competent physicians. However, one cannot help but wonder that with the advent of undreamed government research dollars and the increase in limited specialties, if the pendulum has not swung too far to the left.

It is high time that we returned to Dr. Osler's original ideas. It is high time we returned to the realistic and effective program of having physicians who practice what they preach—teach what they practice.

The ever-widening gulf between patient-oriented private practitioners and research-oriented, full-time medical faculties is the greatest and the gravest threat to the medical profession today.

Personal Responsibility Still Alive

In this short roadmap of the future I have a deep conviction that at the heart of America there still are great numbers of those who believe in the superiority of individual freedom and responsibility over government mediocrisy.

Somehow, in some way, we as physicians, as doctors of medicine, must make that heart of America beat more vigorously rather than permitting the

transplant of a foreign heart already rejected wherever it has been tested.

As physicians, we must get involved. To the doctor who says, "I can't afford to take the time," I say in all sincerity:

"Doctor, if you value your freedom and your sons' freedom, **you can't afford not to take the time.**"

In my considered opinion, your Ohio State Medical Association has led the nation in offering guidelines to our members to keep them free from government shackles and in keeping them informed and warned against current government programs.

The response of the members has been in some areas, excellent, in some areas, fair, in some areas, disheartening. To win this battle, we must get more involved.

We must be more alert.

We must learn to act more quickly.

We must lead and not be led.

No one knows better than the practicing physician what America needs to remain healthy.

Although we cannot be 100 per cent certain of the road ahead, we know the journey has begun.

If the road ahead seems like a nightmare let us recall that one can resolve a nightmare only by "waking up."

I think America is awakening.

I think Americans are looking for leadership—to lead us back to soundness and integrity and mutual trust.

At the Battle of Bunker Hill, the colonial forces were disoriented—without leadership — completely chaotic.

In their midst came a man who knew he had "to take the time."

He was a successful man.

He was a family man.

He was a man of considerable means and respect.

But he knew he had to "take the time."

He organized the colonial troops.

He directed their defenses.

He held them against the best mercenaries and weapons in the world.

He gave his life at Bunker Hill.

Gentlemen, **he was a doctor of medicine who took the time.**

"Won't you take the time?"

The University of Wisconsin Medical School Division of clinical oncology, will hold its eighth annual National Cancer Conference August 22-24 at the Park Motor Inn, Madison. The conference—"Cancer Chemotherapy '68"—is open to all United States physicians interested in cancer chemotherapy.

Physicians in Mental Hygiene Field To Meet in Mansfield, July 12

The Association of Physicians of the Ohio Department of Mental Hygiene and Correction will hold its next meeting July 12 at the Ohio State Reformatory, Mansfield.

The meeting will start at 9:00 A.M. and end at 4:00 P.M. During the morning there will be a tour of the institution. In the afternoon talks will be given on "Some Aspects of Penology" by Bennett J. Cooper, superintendent; Bernard Barton, assistant superintendent; and Robert White, psychological supervisor, all at the Ohio State Reformatory in Mansfield.

A short business meeting will be conducted by Julius Nemeth, M.D., Woodside Receiving Hospital, president of the organization.

The scientific part of the program will be presented by Jankiel Barg, M.D., Fairhill Psychiatric Hospital, program chairman; and Russell C. Long, M.D., Ohio State Reformatory, program committeeman.

All physicians, regardless of whether or not they are members of the organization, are invited to attend. In addition, interested paramedical personnel are invited. Additional information may be obtained from Virginia S. Edwards, M. D., Mt. Vernon State Hospital, secretary-treasurer of the organization.

Ohio Physicians' Group Held Taxable as Corporation

The U. S. District Court for the Northern District of Ohio, Eastern Division, recently ruled in favor of a Cleveland based group of physicians with corporate status under provisions of the Ohio Revised Code Section 1785.01 et seq., in regard to income tax treatment.

Following is a brief comment on the decision as given by the Law Department of the American Medical Association:

"A professional corporation set up by 14 radiologists to provide services to hospitals and individual patients was held by a federal trial court in Ohio to be entitled to the tax advantages of a corporation. This is the second time a federal court has held invalid the Treasury Department's *Kintner* regulations, which restrict professional groups in obtaining corporate tax status. The first decision was handed down by the federal district court in Colorado in *Empey v. U.S.* (reported in full text with Vol. 16, No. 1 of THE CITATION). Full text of the court's decision in the Ohio case is included as an attachment with this issue of THE CITATION. *O'Neill v. U.S.*,—— F. Supp.——(D.C., N.D. Ohio, Feb. 21, 1968)."

Physicians interested in more details on the court's decision are invited to write to the Ohio State Medical Association headquarters office in Columbus for Xerox copies of the text referred to in the foregoing note.



et's be specific about Campbell's Soups...
and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

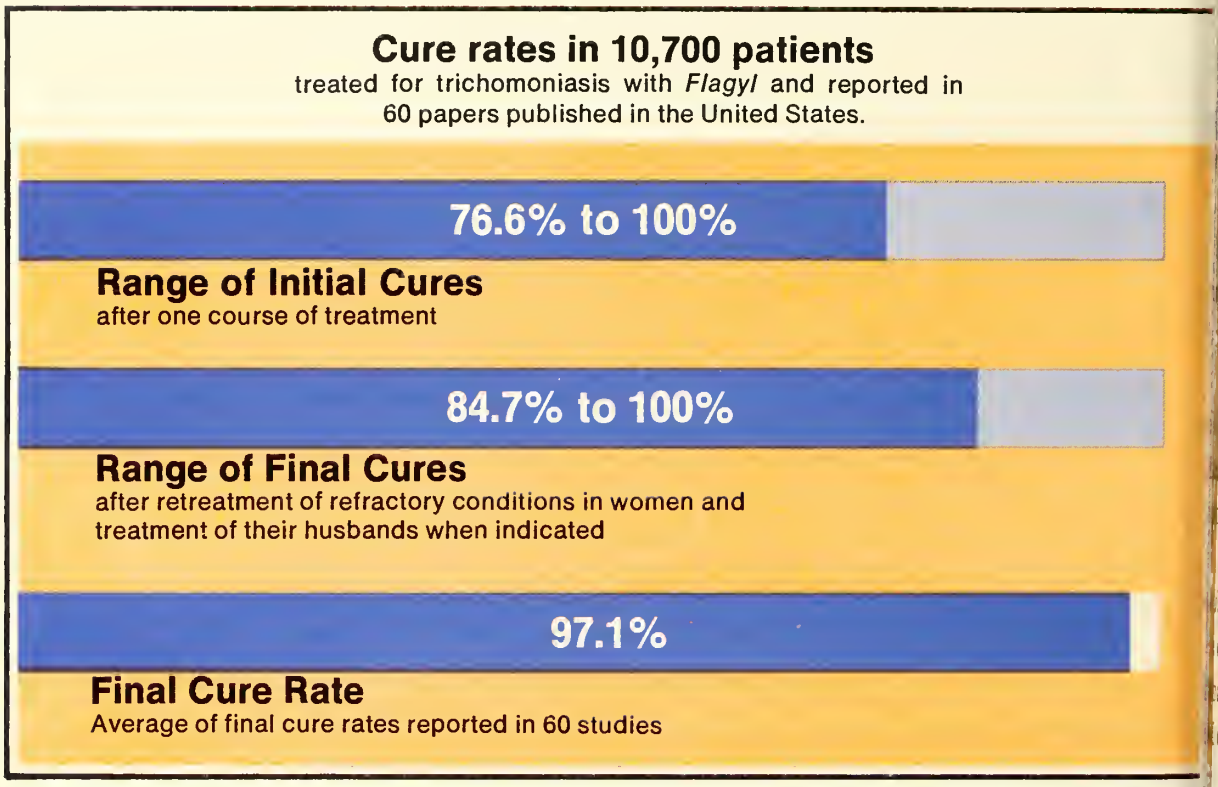
Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
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True Drug Failure...

How often does it occu



Indications: Flagyl is indicated only in the treatment of trichomoniasis in both men and women.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects: Infrequent and minor side effects include nausea, metallic taste and furry ton Gastrointestinal disturbances, flushing and h ache sometimes occur, especially with conc itant ingestion of alcohol. The taste of alcoh beverages may be altered. Other effects, all ported in an incidence of less than 1 per cent, diarrhea, dizziness, vaginal dryness and burn dry mouth, rash, urticaria, gastritis, drowsi insomnia, pruritus, sore tongue, darkened u anorexia, vomiting, epigastric distress, dysu depression, vertigo, incoordination, ataxia,

ith Flagyl®?

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metronidazole

inical practice an occasional uncooperative or drug-sensitive patient
ouse makes 100 per cent cure of trichomonal vaginitis in large series
tients difficult.

Further a very few patients who apparently absorb Flagyl poorly
a few rare instances of trichomonads resistant to Flagyl have been
rted. Nevertheless, approximately half the United States investiga-
report a final cure rate of 100 per cent with Flagyl.

Sixty papers[1] published on the use of Flagyl in trichomoniasis in the
ed States and comprising a total of 10,700 patients have been evalu-
. In thirty of the papers it was declared that all patients adequately
wed and treated were free of trichomonal infection.

Analysis of all of these papers shows that the incidence of cures for
nitial course of therapy ranged from 76.6 per cent to 100 per cent.
cure rates after retreatment of female patients and treatment of their
sands when indicated ranged from 84.7 to 100 per cent. The average
cure rate reported in all investigations was 97.1 per cent.

nal cramping, constipation, stomatitis,
ness or paresthesia of an extremity, joint
, confusion, irritability, weakness, cystitis,
c pressure, dyspareunia, fever, polyuria, in-
nence, decreased libido, nasal congestion,
itis and pyuria. Elimination of trichomonads
aggravate candidiasis.

ge and Administration: In women: one
ng. oral tablet three times daily for ten days.
ginal insert of 500 mg. is available for local
py when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

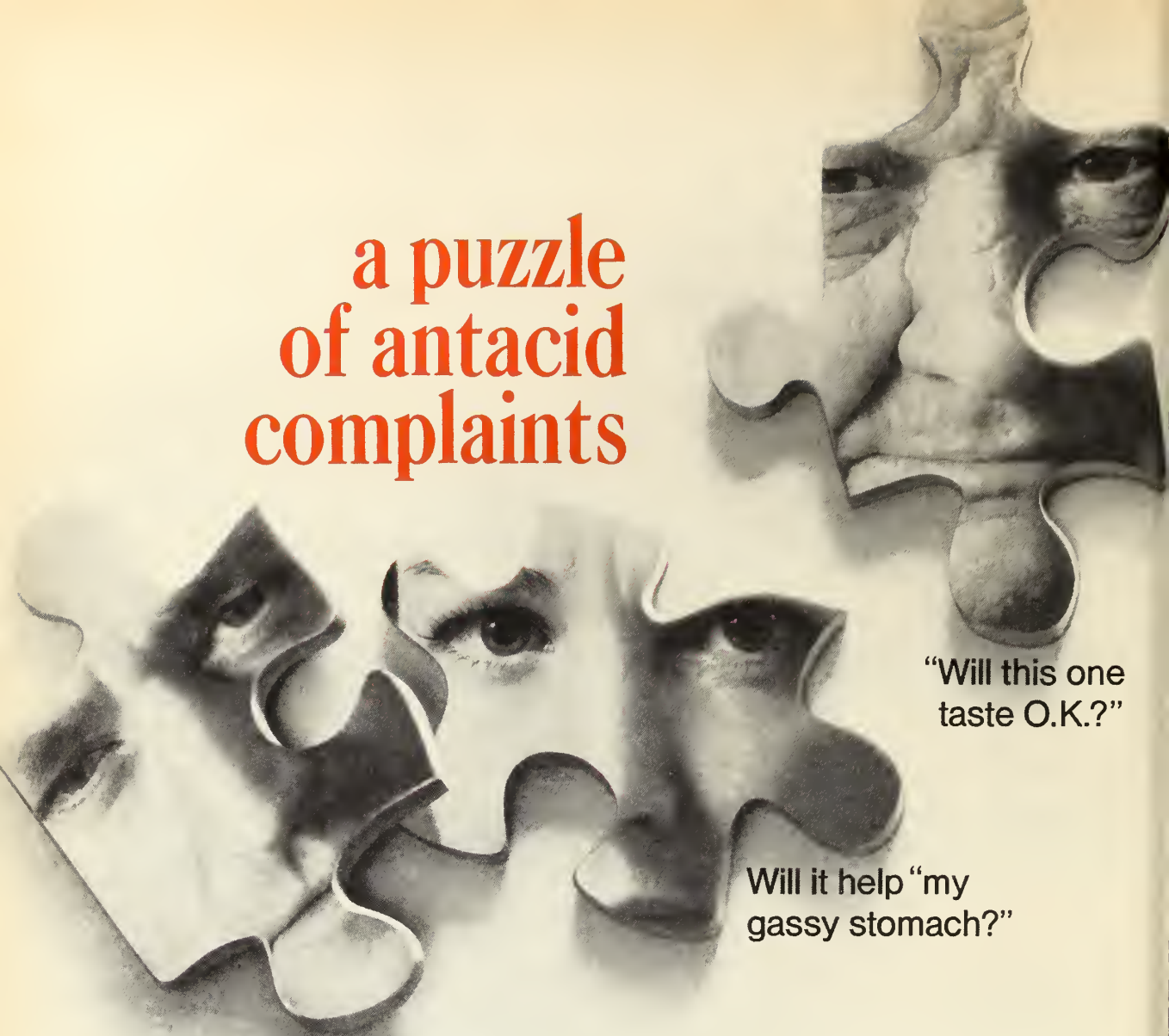
Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

1. Complete list of references on request.

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in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart

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Impact of Federal Government Upon Medical Care

By ROBERT E. HOWARD, M.D.

1967-1968 President, Ohio State Medical Association

AS I LEAVE THE OFFICE of President of the Ohio State Medical Association, I would like to share with you some of my concern as to what changes are currently being imposed on the private practice of medicine. The Government control of medicine through laws, regulations, and rules is beginning to show its impact locally, on the state level, and federally in the changing patterns of Health Care.

Some doctors in full-time teaching in medical schools or hospitals along with public health physicians will favor the trend of government reimbursement and control of Health Care. The social evolution will not affect them financially since they are on a fixed salary. Many a doctor in planning programs admits — and I quote one prominent doctor from England now in Region V, Chicago, Social Security Administration — that he is a parasite, but enjoys his position.

With the passage of Medicare and Medicaid, Congress forced open the door to federalized medicine, and a great social experiment began in our country which has tried and has failed in other countries.

Our own American Medical Association, in attempting to satisfy both liberal and conservative physician members, has caused considerable concern in recent conferences on Medical Care for the Poor and in the First and Second Socioeconomic Congresses on Social Changes in Medicine and Group Practice.

The weakest link in American medicine is the inability of the busy average physician to understand in depth what is happening to our profession.

The second weakest link is that our university medical schools are now captives of the federal government because of approximately 70 per cent subsidy through federal funds.

The third weakest link is the failure in some county and state medical societies to pass on AMA action as well as on health legislation with bilateral discussion among members before these proposals are enacted into law. I do not believe many doctors are convinced that Office of Economic Opportunity health centers, regional health programs, and partnership in health plans have brought efficiency, economy, or quality health care to many, many areas. The voluntary programs as evidenced in many cities are far more practical and effective.

Enslavement by Default

These weaknesses, unless corrected at once — and it may already be too late — will lead to the enslavement of the medical profession by the federal authorities with the approval of organized medicine.

The greatest insult ever handed to medicine was the appointment by President Lyndon Johnson of Wilbur J. Cohen, as Secretary of Health, Education, and Welfare. Since the Senate must approve this appointment to make it official, it is hoped enough citizens will show objections, so this tragedy may be avoided. This man works in subterranean passageways and blinks like a startled mole when exposed to light or right. He is a bureaucrat and a manipulator, but I believe, from documented reports of his activities over the last 30 years in the published book, *Wilbur Cohen: The Pursuit of Power,* he can be controlled. Most members of the medical profession who know him hope he will be ousted from this position, either now or after the November election — before he completely socializes medicine and degrades the quality of health care through his rules, regulations, and experiments which are now his to use under Public Law 90-174, passed in November 1967.

He speaks with unmerited authority on **health, medicine, education, and research—fields in which he has no expertise whatsoever.** Neither an innovator nor a creator, Cohen has capitalized on the creative work of others, especially that of Bismark, the Communists, Michael M. Davis, and his former chief, Isidore S. Falk, whose dream he so cleverly hijacked.

Following an unbelievable pattern of deceit, Wilbur Cohen has misled five presidents, the Congress, and the American people about the meaning of Social Security legislation he sponsored. His statistics and cost estimates are suspect as is the man himself.

Controlling Medical Costs

California Medical Association voted at its annual meeting to oppose vigorously Senate continuation of Wilbur Cohen as Secretary of HEW. This

is significant since experiments such as the British Health Plan to control medical costs through per capita reimbursement with a ceiling on charges already have been authorized for 22,000 families in four counties of California. Cohen is committed to expanding health care for all ages through prepaid closed panel group practice, consumer or government controlled, or the British method of compulsory comprehensive health care federally financed, as is Medicare Part A in the United States.

What can doctors do to stop this avalanche of government interference in the practice of medicine?

Doctors have the opportunity for nonparticipation — or call it individual responsibility to the patient — to counteract government interference. In four provinces in Canada, the doctors have taken this action and the Canadian medicare law has been delayed for further negotiations and determination of priorities.

The health professions, as in California are expected, first by threat and then by force, to reduce their normal fees and charges to subsidize another government failure and socialist miscalculation, just as we are doing in Ohio under Title 19.

It is high time to show Wilbur Cohen, Phillip Lee, Robert Ball, and liberal politicians and administrators that doctors — not bureaucrats — practice medicine. We will not, I hope, permit our medical system to deteriorate, as happened in England, Sweden, and other countries, by allowing HEW to implement major and illegal regulatory changes not in the law.

Direct Billing is OSMA's most important weapon in preserving the private practice of medicine. However, OSMA does not practice medicine. Its members do. Only the members can make this policy effective by directly billing all patients. (Summit County is to be complimented for its courage and leadership in this and in its **contract review policy.)** It must be emphasized to the individual physician that **separate billing and direct billing** are not one and the same.

Matter of Ethics

Under the recent Medicare amendments, Medicare may pay for in-hospital medical services as part of the **per diem** contract under Part A. Blue Cross and SSA are urging hospitals to adopt this mechanism. This is a violation of ethics because (1) the per diem basis would cause the hospital to be paid for a medical service (even if a physician shares that payment), and (2) more importantly, the per diem rate would be the same, regardless of whether or not the patient received the medical services covered by the per diem.

Public Law 239, Heart Disease, Cancer and Stroke, just points out that there appears to be a mad scramble to get "239" funds, since the four programs in Ohio claim a total of 105 of Ohio's 88 counties — this is a mathematical impossibility, but is the usual bureaucratic force. They have the cart before the horse in most programs so far. They are granted money and then go out to find the need.

Under P. L. 749, it appears that, despite a 40- to 45- member State Health Planning Council, OSMA will have only one representative on the committee.

Medicine must remember that (1) P. L. 749 is here and is being pushed heavily. Private medicine must guide it on a policy-making level, and it is distinctly possible that a good, comprehensive plan can come up with the conclusion that there is, in the planning area, no need for new services or for a change in the method of delivery of existing services. Wouldn't this disappoint Wilbur Cohen?

Medicine should use the approach that, just because some agency says there must be planning, this does not mandate there must be a major change in operations and services included in the planning.

Sound Planning

If comprehensive health care planning is to succeed, it must be conceived in the form of a wheel, with medical care as the hub and ancillary services as the spokes of the wheel. The coordination and direction of these services act as the band or tread on which the wheel moves.

Such planning must be based on sound medical orientation and meaningful physician participation. To achieve this, the House of Delegates of the Ohio State Medical Association resolved that OSMA "reaffirms its previous position of encouraging active physician participation, through County Medical Societies, on areawide health care planning boards, with full voting rights."

Too frequently in the past, Ohio medicine has been confronted with situations where community groups, without physician consultation or participation, have established health care programs, and then have requested physician participation **after the fact.** Physicians have then attempted to obtain positive changes in these programs, only to be accused of acting as "obstructionists."

If comprehensive health planning is to succeed— if it is to accomplish evolution rather than revolution — we first must focus our attention on the health resources and facilities at the community level. We must develop a community partnership in terms of the contributions each resource and facility can make to the overall plan.

We must ensure appropriate and meaningful roles for these community providers of service, rather than to create artificial needs and programs.

We must assure that these programs are designed to help those who need help, rather than offering "a little something for everybody."

Above all, and on this medicine will stand, we must make certain that programs are designed on

a basis of established need and not wistful fancy, and we must insist that any program is designed to take services to the people, rather than bringing people to the services.

It is important that areawide planning groups follow our OSMA guidelines and general policies for all government medical care.

Overwhelming Demands

To quote Dr. Milford O. Rouse, President of the American Medical Association:

"Demands being made on the medical profession, as the natural leader of the health care field, are overwhelming.

"The chorus of citizens demands that we double, and then double again our capacity to provide prompt care to every person who wants it. It demands that at the same time, we maintain the highest quality of care and continually improve it. And then it demands that while we are doing those things, we reduce the cost of health care; that, in fact, we alone swim upstream successfully against the swift and battering currents of nationwide inflation and the constantly rising cost of all goods, services and personnel.

"All problems can be solved only with time, and through effective action by the people involved and by those who sincerely wish to help."

The 'Instant Health' Urge

Government restlessness for instant doctors and instant health care spells cheap medicine and drugs with controls. The British Fellowship for Freedom, which is like the Association of American Physicians and Surgeons, was formed in August, 1948, to attempt to secure an amending bill which would fundamentally change the character of the British National Health Service.

At that time, the Fellowship had to define what should be the relationship with other professional organizations and, in particular, with the British Medical Association. Large numbers of doctors were filled with bitterness toward the BMA. They had stood up manfully to the threats of the government, in loyalty to the seven cardinal principles laid down by the BMA, only to find on May 28th that the citadel or ivory tower had surrendered over night.

The members of Fellowship for Freedom then decided:

(1) To write to professional journals, either initiating or following up the discussion of major health issues and so helping to keep their point of view before colleagues, although the legislation was passed.

(2) They decided to help build up public opinion by informal letters to national or local press.

(3) They decided to help influence Parliament by writing and talking to representatives from local areas. Doesn't this sound like a preview of what is happening to us, especially with Wilbur Cohen in control of Health, Education, and Welfare? Don't be afraid to speak up now, before it is too late.

Attempts to Change Things

The latest attempt to change medicine, such as control medical costs, is called "Guidelines for Incentive Reimbursement and Experiments as Approved in Section 402 of the 1967 Social Security Amendments."

The amendments would use tax dollars for experimental plans of a broad type involving substantial changes in methods of reimbursement, for example, by capitation plan, or (2) consider a plan to integrate medical service in a combined physician-hospital extended care plan. There are eight guidelines in all, with prepaid, closed panel lay control emphasized.

At the Socioeconomics Congress

Recently, at the AMA Socioeconomics Congress, your President was a "demonstrator" for the private practice of medicine, as reported in the April 8 issue of *The AMA News*. I stated at this Congress:

"Thank you, Mr. Chairman, for the privilege of briefly discussing the subject of group practice, which has been broadly and forcefully presented at this Congress. I am Robert E. Howard, of Cincinnati, Ohio. I am President of the Ohio State Medical Association.

"The loose use of the term 'group practice' by the social planners as their goal for health care is a semantic steal which many physicians, including myself, deeply resent.

"I believe that the private practice of medicine, be it solo practice, single specialty or multispecialty group, as predominates in these United States, can and will continue unless the socialists in government and labor completely socialize medicine.

"You will note that I refer to these interests as socialists. You will note that I refer to their goals as socialized medicine. Ladies and gentlemen, they are socialists and their goal is socialized medicine. You may call it government medicine, liberal medicine, or consumer medicine, but, if you call a spade a spade, it is socialized medicine.

"Due to the legislation generated during the 89th Congress, the Cities Demonstration Act, the Comprehensive Areawide Health Planning Act, and the Economic Opportunity Act, the Federal definition of Group Practice, as written by the U. S. Department of Health, Education, and Welfare, consists of a prepaid closed panel controlled by consumers, with sal-

aried physicians and absolutely no free choice of physician, or fee for service.

"With HEW and labor using our tax dollars to promote this type of practice;

"With reports from HEW involving misleading comparisons of health statistics of the United States with certain socialist or communist nations;

"With the distorted facts of the Report of the National Conference on Health Care Costs;

"With the preconceived and misleading reports of the National Health Manpower Commission;

"With membership on such commissions and study groups limited only to those persons who agree, in advance, not to submit a minority report;

"With all these efforts aimed at destroying or dividing the American Medical Association and the private practice of medicine, I am convinced that it is time for organized medicine and private practice to to speak up—loudly, clearly, and repeatedly.

"I have yet to see an HEW pamphlet or conference say anything positive for the private practice of medicine. HEW's Conference for Promotion of the Group Practice of Medicine last October was no exception.

Loaded Against Private Practice

"I also said that I hoped all the physicians attending this conference did their homework before coming to Chicago. I hoped that all of them had read the HEW conference propaganda. I hoped they had studied the discussions and recommendations of the seven panels, the blueprint for action as summarized by the Conference Director, Dr. John Cashman, of the U. S. Public Health Service. I refer you to PHS Publication No. 1750. I have the reports from six of the eight doctors attending this conference and they are startling. Do you realize that eight of the speakers on the AMA Congress for Group Practice were also on the HEW program? Only five or six of the speakers were private practitioners of medicine. Evidently, those in private practice are considered too busy with patient care to be called upon to speak.

False Goals of Cheap Medicine

"I have read many articles on group practice, furnished me by the AMA. I have received many letters of concern from doctors in many states — doctors in both private and closed groups. These articles and these letters cemented my serious concern over the false goals of cheap medicine and cheap drugs through government controls, false goals being held out by Washington interests that are deadly enemies of our present system of medical care.

"I concluded by saying, 'I pray that this year will bring hope for the continuance of our fine record of health care under private medicine without government and labor interference.' "

Remember that the November Elections are not far away. I want to stress membership and active participation, financially and personally, in AMPAC and OMPAC. The November election is the most important one since the Civil War.

We must elect a Congress and administration friendly to medicine. This is doubly important since Wilbur Cohen has been nominated to be HEW Secretary.

Ohio Medical Golf Tournament Scheduled at Lima Club

The annual tournament of the Ohio State Medical Golfers Association is scheduled at the Hawthorne Country Club, Lima, on Thursday, June 27. All physicians are invited to participate. Those who are not members of the group and have not received details may contact Mr. Robert W. Elwell, Executive Secretary of the Academy of Medicine of Toledo, 3101 Collingwood Blvd., Toledo.

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Marked Influence of Interviewer Noted in Survey Results

For years survey practitioners and users of survey data have been concerned about problems of inaccuracies in interviews. For example, Myers' study of age data obtained by interviewers in the 1940 Decennial Census found a marked "heaping" of ages ending in zero, such as 10, 20, and 30. Hanson and his colleagues at the U.S. Bureau of the Census conducted reinterviews of families regarding their status in the labor force. Significantly different responses were obtained for about 40 percent of the items of the interview. Hyman reported a study conducted during World War II which showed that nearly half the respondents known to have cashed war bonds during the week previous to the interview failed to report this to the interviewer.

In attempts to isolate and provide techniques for overcoming these problems, early attention was centered upon the interviewer. In 1929 Stuart Rice published a pioneering article entitled "Contagious Bias in the Interview." Rice was working with some interviewers who were collecting information to determine reasons for destitution of men living in cheap hotels and flophouses. In reading the interviews he discovered that various responses received by one interviewer were similar to one another but different from those received by another interviewer. He also discovered that respondents of one interviewer consistently reported overindulgence in liquor as the cause of their destitution while respondents of another interviewer tended to blame social and economic conditions. An investigation showed that the former interviewer was a prohibitionist and the latter a socialist.

Katz showed that interviewers from working-class backgrounds consistently obtained more radical social and political opinions from respondents than did interviewers from the middle class.

Since early studies have demonstrated significant differences between interviewers, it is not surprising that much attention has been devoted to measuring the effect of interviewers on research results and to seeking a means of overcoming potential bias.

The foregoing background information is part of the introduction to a Public Health Service report entitled "The Influence of Interviewer and Respondent Psychological and Behavioral Variables on the Reporting of Household Interviews." The 65-page pamphlet, PHS Publication No. 1000, Series 2—No. 26, is for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price 45 cents.

Comprehensive Areawide Health Planning

Ohio Leaders in Medical Organization Work Meet in Columbus for Discussion and Policy Recommendations

SUGGESTIONS TO GUIDE the Ohio State Medical Association, its component societies and individual physicians in areawide comprehensive health planning were prepared by more than 100 county medical society leaders in Columbus April 17.

Also participating were the OSMA Council and the Committee on Government Medical Care Programs. The statewide conference was sponsored by OSMA.

The suggestions of the participants were arrived at after a discussion of the provisions of Public Law 89-749, Areawide Comprehensive Health Planning, the administrative regulations, and existing OSMA policies.

The suggestions are to be used by the committee in recommending to The Council additional policies and any possible updating of existing policies.

H. William Porterfield, M. D., Columbus, Committee chairman, presided. He outlined OSMA policies regarding P. L. 749, and gave the final summary. Committee Member Dwight L. Becker, M. D., Lima, P. L. 749 Subcommittee Chairman, discussed the provisions of P. L. 749.

Four physicians and one medical society executive explained the comprehensive health planning involvement in their respective areas. Included were Robert A. Lang, Ph. D., Executive Secretary, Academy of Medicine of Cleveland and Cuyahoga County Medical Society; Robert E. Reiheld, M. D., of Orrville (representing the Wooster area); R. N. Smith, M. D., Toledo; Theodore H. Vinke, M. D., Cincinnati; and John P. Stevens, M. D., Columbus.

Following the five talks on area involvement, those attending were assigned to discussion groups. Each



At the rostrum is Dwight L. Becker, M. D., member of the OSMA Committee on Government Medical Care Programs and chairman of the subcommittee on comprehensive health planning.





Part of the audience at the workshop for County Medical Society leaders on comprehensive health planning. At the rostrum is H. William Porterfield, M. D., chairman of the OSMA Committee on Government Medical Care Programs.



Among persons who discussed area involvement in comprehensive health planning were (from left) Robert A. Lang, Ph. D., who discussed the Cleveland area program; Robert E. Reiheld, M. D., Wooster area; Robert N. Smith, M. D., Toledo area; John P. Stevens, M. D., Columbus area; and Theodore H. Vinke, M. D., Cincinnati area.

group conducted a 90-minute "brainstorming" session on problems encountered by physicians with comprehensive health planning in their respective areas.

Group leaders included Elden C. Weckesser, M. D., Cleveland; Dr. Reiheld; Robert N. Smith, M. D., Toledo; Marvin R. McClellan, M. D., Cincinnati; and Paul A. Jones, M. D., Zanesville.

At the concluding general session, leaders of each group delivered short oral summaries of their groups' recommendations and discussions prior to Dr. Porterfield's summary of the entire workshop. In addition, discussion group recorders dictated the recommendations for reproduction as a general report of the conference.

Group recorders were William Dorner, M. D., Akron; William R. Schultz, M. D., Wooster; M. M. Thompson, M. D., Toledo; Theodore H. Vinke, M. D., Cincinnati, and W. T. Washam, M. D., Columbus.

Part-Time Intern, Residency Programs Instituted for Women Doctors

To make it possible for young wives with M.D. degrees to take care of a family and also complete the rigorous hospital training required before they can practice medicine, two of the University Hospitals in Cleveland have established part-time internships and residencies for a few of them. University Hospitals are associated with Case Western Reserve University School of Medicine.

At present five young women, two interns, and three residents, are in training on a part-time basis. The schedules worked out in pediatrics, psychiatry, and child psychiatry for these women doctors, who are also married and have children, reduce their normally long hours by one-fourth to one-half, and lengthen their training periods accordingly.

Cincinnati Physician Is Honored as Pioneer in Anesthesiology Field

A Cincinnati physician was one of four pioneer anesthesiologists who were guests recently at the Wood Library-Museum of Anesthesiology, Park Ridge, Illinois. As a participant in the "Distinguished Visitors Week" program, Dr. Dennis E. Jackson, Cincinnati, joined in discussions of current museum projects and helped identify some of the hundreds of pieces of historic equipment which have been donated.

In noting the honor bestowed upon Dr. Jackson, the American Society of Anesthesiologists said of him: He is credited with having laid the groundwork more than a half century ago in the "closed system" of anesthesiology, whereby the waste products of respiration, namely carbon dioxide, are absorbed in soda lime. It is through the use of this principle that today we are able to maintain life in space and under the sea.

Dr. Jackson also established the value of trichlorethylene as an anesthetic agent, and by so doing, helped to launch others onto the road of discovering many new and valuable anesthetics. Some of the most important pieces of equipment in the Museum were invented by Dr. Jackson. Although retired from practice, Dr. Jackson still spends much time working on new instruments, new methods and special devices pertaining to anesthesia in the completely-equipped workshop in the basement of his home.

The other three physicians honored are Dr. Harold R. Griffith, Montreal, Canada, pioneer in the use of curare in anesthesia; Dr. Ralph T. Knight, Minneapolis, Minn., leader in education of physicians in anesthesiology; and Philip Dudley Woodbridge, Greenfield, Mass., pioneer in many developments and safety measures in anesthesiology.

Four Columbus Physicians Honored At Ohio State Alumni Reunion

Four Columbus doctors were honored at the 15th Annual Medical Alumni Reunion of the Ohio State University College of Medicine, held on April 20 at the Ohio Union.

The awards are being given to the men for their "meritorious service and contributions to medicine, school, and community."

Dr. Charles W. Pavey, class of 1928, is clinical professor emeritus in the Department of Obstetrics and Gynecology at Ohio State. He is a past president of the Columbus Academy of Medicine and the Association of American Physicians and Surgeons. He is a member of the American Board of Obstetrics and Gynecology and a Fellow in the American College of Surgeons.

Dr. Homer Anderson graduated from the College of Medicine in 1943. He has been a faculty member in the Department of Pediatrics since 1946, and is a past chief of staff of Children's Hospital. He also is a past president of the Columbus Academy of Medicine, as well as a member of several other professional organizations.

Dr. Horace B. Davidson, a member of the class of 1933, is director of Davidson Laboratories and chairman of pathology at Mt. Carmel Hospital. He is clinical professor of pathology at Ohio State, and has been on the teaching staff for 36 years. He serves as consultant pathologist to several hospitals in the community. He is a past president of the Columbus Academy of Medicine and a member of several medical groups. His brother and his eldest son are also graduates of Ohio State.

Dr. Floyd M. Beman holds joint appointments as professor in the Department of Medicine and Physiology. He graduated from Ohio State in 1943 and returned as a faculty member in 1950. He is a Fellow in the American College of Physicians and a member of the American Federation for Clinical Research.

President Novice G. Fawcett, Dr. Richard L. Meiling, dean of the College, and Richard M. Mall, alumni secretary, greeted the returning alumni at a luncheon honoring the class of 1918. They received certificates in recognition of their 50 years in the medical profession.

State Health Director Designates Nelsonville Facility Official Housing for TB Patients

Dr. Emmett W. Arnold, director of the Ohio Department of Health, recently issued the following directive for public information and addressed specifically to health commissioners, boards of county commissioners, probate court judges, and tuberculosis hospitals:

Subject: New location of tuberculosis facility operated pursuant to Revised Code sections 339.50 to 339.64, inclusive.

"Notice is hereby given that pursuant to sections 339.50 to 339.64, inclusive, of the Revised Code, I have designated, effective May 1, 1968, the Southeast Ohio Tuberculosis Hospital, Nelsonville, as the facility to be used for the purpose of housing persons with communicable tuberculosis who have been removed by a Board of Health pursuant to section 339.52 of the Revised Code. The Director of Health's designation of the Ohio Tuberculosis Hospital, Columbus, on November 4, 1957, as such a facility has been rescinded.

"The Medical Superintendent and the medical, executive, nursing, dietary, maintenance, and rehabilitation personnel of the Southeast Ohio Tuberculosis Hospital have been designated as the staff for this new facility.

"Accordingly, persons formerly hospitalized at the Ohio Tuberculosis Hospital pursuant to O.R.C. section 339.52 have been transferred to the Southeast Ohio Tuberculosis Hospital."

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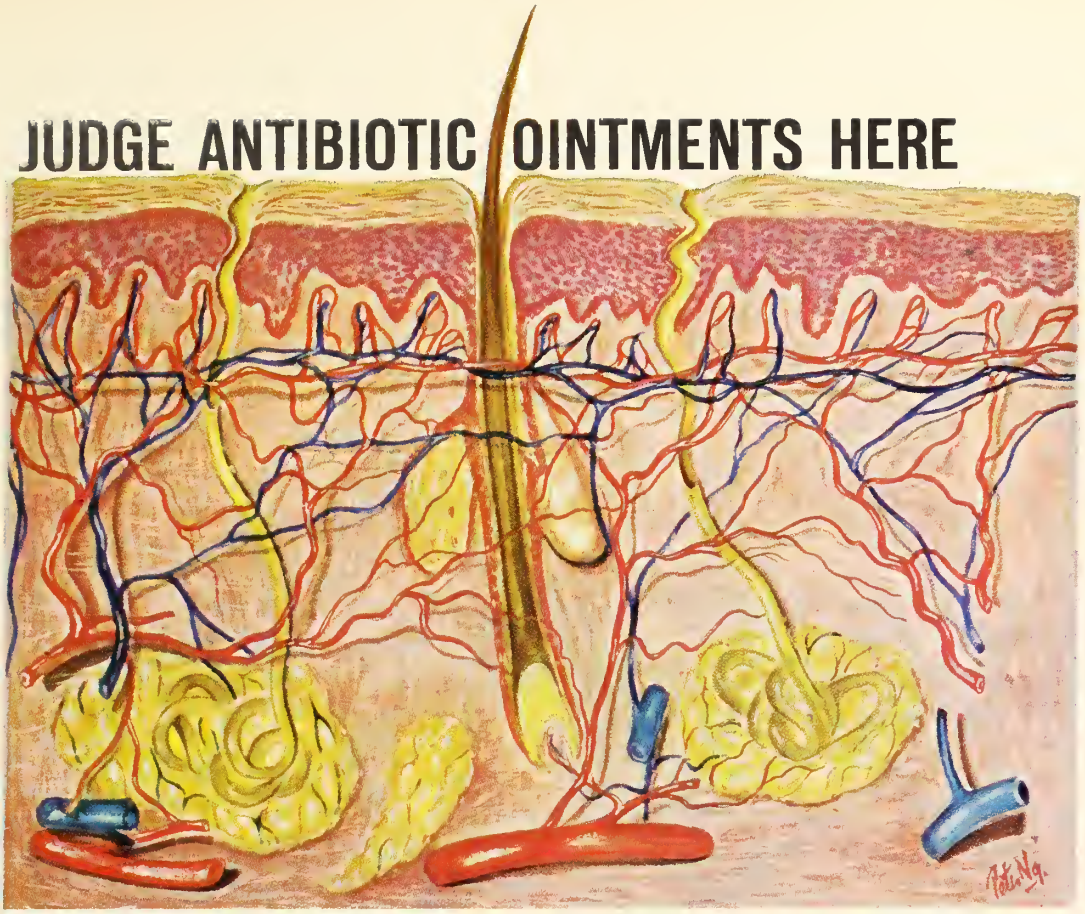
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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

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BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

Tegretol®
carbamazepine

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the d should be discontinued.
2. Liver function tests must be performed at regular intervals during ment with this drug since liver damage may occur during therapy. Th drug should be discontinued immediately in cases of aggravated live dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and ton etry, are recommended for patients being treated with this drug sinc many phenothiazines and related drugs have been shown to cause ey changes.
4. Complete urinalysis and BUN should be done on patients treated Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocyt eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities liver function tests, cholestatic and hepatocellular jaundice, urinary f quency, acute urinary retention, oliguria with elevated blood pressure albuminuria, glycosuria, elevated BUN, microscopic deposits in the u impotence, disturbances of coordination, confusion, headache, fatigu blurred vision, transient diplopia and oculomotor disturbances, speec disturbances, abnormal involuntary movements, peripheral neuritis a paresthesias, depression with agitation, talkativeness, nystagmus, lin nitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndro photosensitivity reactions, alterations in skin pigmentation, exfoliativ dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, en multiforme and nodosum, aggravation of disseminated lupus erythem tosus, gastric distress, abdominal pain, diarrhea, constipation, anore dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramp conjunctivitis, left ventricular failure, aggravation of hypertension, hy tension, syncope and collapse, edema, aggravation of coronary arter disease and congestive heart failure. (Whether these cardiovascular are drug-related is not known. However, some of these complication resulted in fatalities.) The necessity for discontinuing the drug shoul dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with m if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the should be increased in one-half tablet (100 mg.) increments every 12 until freedom from pain is achieved. To relieve pain, between 200 mg 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patie with a dose of 400 mg. to 800 mg. daily. Maintenance doses may ran between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts shoul made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottle of 100 and 1000. (B)46-82
For complete details, please see Prescribing Information.

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when you want to provide the combined benefits of two accepted agents in the treatment of mild to moderate hypertension. (Contraindications: history of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.)

when you want to prescribe therapy that is generally well tolerated.
(However, adverse reactions may occur. For a complete listing, please refer to the full prescribing information which is summarized below.)

when your patient wants an easy-to-remember and reasonably priced regimen. (One tablet a day usually costs about a dime.)

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue 1 week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn. **Precautions:** Antihypertensive therapy with Regroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. **For details, see complete Prescribing Information.** (B)46-600-B

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Obituaries

Ad Astra

Cecil Frederick Barber, M. D., Ft. Lauderdale, Florida; University of Illinois College of Medicine, 1927; aged 68; died April 22; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. An Ohio practitioner of long standing, Dr. Barber was in Felicity until about a year ago, and was a past president of the Clermont County Medical Society. Among survivors are his widow, two daughters, three sons, a brother, and a sister.

Gerald L. Brody, M. D., Ann Arbor, Mich.; Western Reserve University School of Medicine, 1949; aged 41; died March 31. A native Ohioan, Dr. Brody moved to Ann Arbor where he took his residency training in pathology. He was a diplomate of the American Board of Pathology and was on the faculty of the University of Michigan. Surviving are his widow, two daughters, his mother, and a sister.

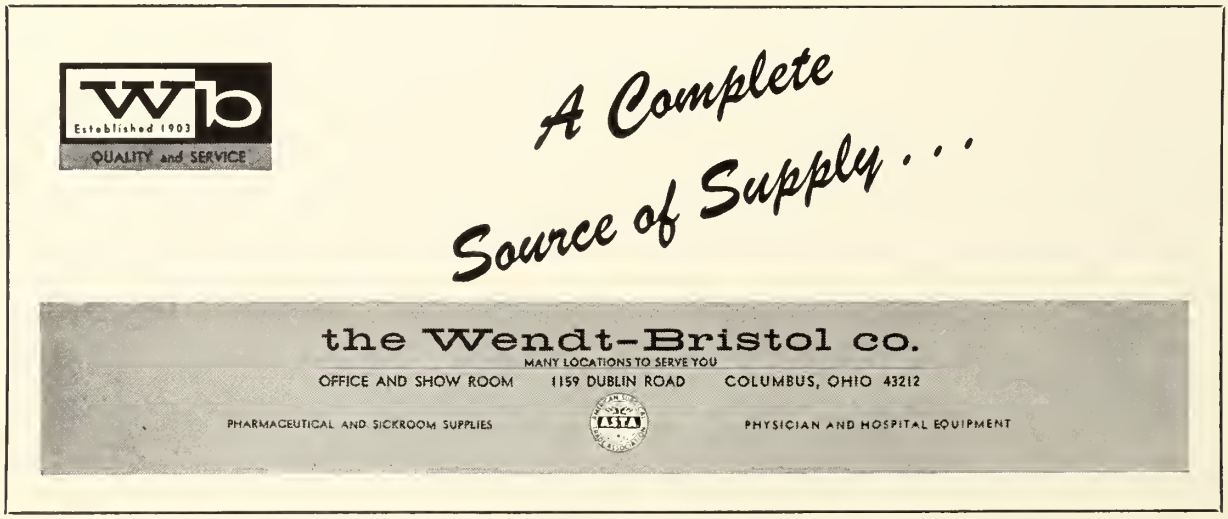
Leo D. Covert, M. D., Bellaire; Western Reserve University School of Medicine, 1918; aged 78; died April 15; member of the Ohio State Medical Association and the American Medical Association. A Bellaire practitioner of long standing, Dr. Covert specialized in the EENT field. Among affiliations, he was a member of the Presbyterian Church, Americus Club, and the Kiwanis Club. He was a veteran of World War I, and a past commander of the local American Legion post. Survivors include his widow, a daughter, and a son, Dr. Donn F. Covert, of Warren.

Theodore P. Day, M. D., Cleveland; Ohio State University College of Medicine, 1933; aged 60; died March 30; member of the Ohio State Medical Association and the American Medical Association. A practitioner in the Cleveland area, Dr. Day was medical examiner for the Pennsylvania Railroad. During World War II he served with the Medical Corps. Survivors include his widow, a son, a stepson, and a sister.

Albert Homer Dyson, Jr., M. D., Cleveland; Meharry Medical College, 1940; aged 56; died April 27; member of the Ohio State Medical Association, former member of the American Medical Association, and member of the Ohio Academy of General Practice. A practitioner in Cleveland for about 20 years, Dr. Dyson came to Ohio from Washington, D. C., where he was associated with the U. S. Public Health Service. Among affiliations he was a member of the National Association for the Advancement of Colored People. Surviving are his widow, a daughter, a son, his mother, and two sisters.

Clyde Wilmer Everett, M. D., Portsmouth; University of Nebraska College of Medicine, 1935; aged 56; died April 15; member of the Ohio State Medical Association, the American Medical Association, American Society of Abdominal Surgeons; Fellow of the American College of Surgeons. A practitioner of long standing in Portsmouth, Dr. Everett's specialty was general surgery. He served in the U. S. Army from 1940 to 1945 on active duty, and in the Medical Corps Reserve he held the rank of lieutenant colonel. He is survived by his widow, two daughters, a son, and a brother.

James E. Gorman, M. D., Toledo; St. Louis University School of Medicine, 1931; aged 62; died April 18; former member of the Ohio State Medical Association. A lifelong resident of Toledo, Dr. Gorman was in private practice there for the early part



of his professional career. For the last 15 years he was director of the city's Alcoholic Rehabilitation Clinic and was medical examiner for the local board of education. He is survived by his widow, two sons, a daughter, two sisters, and a brother.

Michael Ludwig Michaelis, M. D., Zanesville; Faculty of Medicine of the University of Erlangen, Germany; aged 71; died April 4; member of the Ohio State Medical Association and the American Medical Association. A former practitioner in Germany, Dr. Michaelis left there in 1939 and practiced for a while in China before coming to this country. He became associated with the sanitorium in McConnelsville in 1950 and opened a private practice in Zanesville in 1955. He was a member of the Temple and B'nai B'rith. Surviving are his widow, a son, and a sister.

Halstead S. Murat, M. D., Middletown; Indiana University School of Medicine, 1910; aged 85; died April 19; member of the Ohio State Medical Association, the American Medical Association, and the Industrial Medical Association. Dr. Murat was company physician for the Armco Steel Company in Middletown from 1917 to 1946. Later he became city physician. Among affiliations, he was a member of the Methodist Church and the Masonic Lodge. A sister, with whom he resided recently survives.

Charles Ernest Newbold, M. D., Eaton; Ohio State University College of Medicine, 1925; aged 73; died April 20; member of the Ohio State Medical Association and the American Medical Association. A practitioner of some 42 years standing in the Eaton community, Dr. Newbold was associated with many community affairs. He was a former president of the Preble County Board of Health; was a member of the Masonic Lodge and the Methodist Church. As a veteran of World War I he was a member of the American Legion. Survivors include his widow, a daughter, and four brothers.

Allan Blythe Rapp, M. D., Owensville; University of Cincinnati College of Medicine, 1911; aged 86, died April 23; member of the Ohio State Medical Association and the American Medical Association. Belonging to a pioneer Clermont County family, Dr. Rapp practiced in the Owensville area for more than half a century, and was a former county coroner and county health commissioner. He was active in many community affairs, was a member of the Methodist Church and a 33rd Degree Mason. His widow survives.

William H. Ries, M. D., Chillicothe; State University of New York Downstate Medical Center, 1937; aged 65; died April 26. Dr. Ries was associated with the Veterans Administration and had been stationed at the Chillicothe VA Hospital for about 16 years. He was a veteran of World War II. Survivors include three daughters, two sisters, and a brother.

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Make tuberculin testing routine with every physical examination.



TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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Herbert Nelson Smith, M. D., Brookville, Ind.; University of Cincinnati College of Medicine, 1920; aged 75; died December 15. Records indicate that Dr. Smith served most of his professional career in the Indiana community of Brookville.

Stanley Wesley Smolik, M. D., Cleveland; Western Reserve University School of Medicine, 1912; aged 75; died April 29; former member of the Ohio State Medical Association and the American Medical Association. Dr. Smolik's professional career spanned some 54 years and for much of that time he was a general practitioner in the Southeast Cleveland area. He was formerly associated with the faculty of Western Reserve. Two daughters and a brother survive.

Paul J. Towell, M. D. Cleveland; Western Reserve University School of Medicine, 1928; aged 64; died April 24. A practitioner for many years in Cleveland, Dr. Towell was a member of the American Rheumatism Association. He was a member of the Catholic Church and the Catholic Physicians Guild. A daughter, two sons, and three brothers survive.

David T. Whitcomb, M. D., Hagerstown, Md.; Ohio State University College of Medicine, 1952; aged 39; died March 25; former member of the Ohio State Medical Association; member of the American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. Dr. Whitcomb went into military service early in his career. He was a member of OSMA through 1955.

Activities of County Societies . . .

BELMONT

The Belmont County Medical Society and the Auxiliary met on April 18 at the Belmont Hills Country Club for an afternoon program and dinner. Program speaker was Dr. Wesley Furste, Columbus, chairman of the Ohio Committee on Trauma of the American College of Surgeons, whose topic was, "Tetanus Prophylaxis—A Century of Progress."

HAMILTON

The Third International Symposium on Cancer—Carcinoma of the Lung—was held in the Academy of Medicine of Cincinnati auditorium on April 16. The program was jointly sponsored by the Academy, the American Cancer Society, and the Cincinnati Surgical Society.

Speakers on the program were Dr. Philip R. Allison, Nuffield Department of Surgery, Oxford, England; Dr. Alton Ochsner, professor of surgery, Tulane University; Dr. R. Robinson Baker, associate professor of surgery, Johns Hopkins University; and Dr. William A. Altemeier, professor of surgery, University of Cincinnati.

LORAIN

A large attendance of members and wives marked the May 7 dinner meeting of Lorain County Medical Society at Oberlin Inn. Guests included Councilor of the Eleventh District, William R. Schultz, M. D., of Wooster and Mrs. Schultz.

During a brief business session prior to the evening's program, President Delbert L. Fischer, M. D., briefly outlined the newly formed Lorain County Comprehensive Health Planning Association. He introduced Lawrence C. Meredith, M.D., chairman of the Government Medical Care Committee, to give a resume of the initial steps taken by the Medical Society in the formation of this group, reminding the members of the impact of P. L. 89-749 on matters pertaining to the medical profession.

Following the business meeting the film "Discover America" was presented to the audience through the courtesy of Myers Travel Bureau of Lorain, who provided travel brochures for those who expressed interest.

LUCAS

The program for the Academy of Medicine of Toledo meeting of April 17 was a feature of the Northwestern Ohio Institute for Continuing Medical Education Lecture Series. The program was cosponsored by the Ciba Pharmaceutical Company and the Tuberculosis Society of Toledo and Lucas County. All physicians of Northwestern Ohio were invited.

Program speaker was Dr. Edward A. Gaensler, professor of surgery, Boston University School of Medicine, whose topic was "Chronic Pulmonary Insufficiency." The speaker conducted hospital rounds in the morning and afternoon.

MAHONING

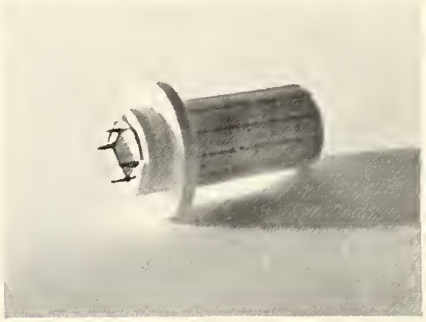
"Medicine and the Sexual Revolution" was the topic discussed at the April 18 combined meeting of the Mahoning County Medical Society and the Auxiliary. Program speaker was David M. Reed, Ph. D., M. P. H., director of training, University of Pennsylvania School of Medicine.

A social hour and dinner preceded the meeting in the Mural Room, Youngstown.

Dr. Norman H. Baker, Columbus, has been invited to present a paper entitled "The Significance of Extra-Luminal Aortic Perfusion Following Acute Thoracic Aortic Dissection," at the annual June meeting of the University of Maryland Surgical Society in Baltimore.

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Make tuberculin testing routine with every physical examination.



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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuoerculosis. Available in 5's and 25's.

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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

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Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

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2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Each yellow tablet contains:
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Dose: 1 tablet 3 times daily.
Available:
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Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
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Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
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Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.

***Dose:* 2 tablets daily.**
***Available:* Bottles of 60, 500.**

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Android—E

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Glutamic Acid . . . . . 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE.** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Cincinnati MEDICO Volunteer Describes His Experiences

Dr. Mark T. Hoekenga, Cincinnati, recently returned from serving as a MEDICO volunteer in Santa Rosa de Copan, Honduras, and gave a brief but vivid description of the crying need for skilled medical aid in such underdeveloped countries. In his evaluation of his MEDICO visit, Dr. Hoekenga wrote:

"I found the hospital to be pretty much as described in the CARE/MEDICO literature. Although the wards were clean and orderly, the conditions for patients were very poor. For the first ten days of my visit; the weather was cold and rainy, and patients shivered under one thin blanket per bed in unheated wards. Many beds were occupied by two patients and occasionally by three. In such instances they shared one blanket.

"There is no hot water and, frequently, the cold water is in short supply as well, which means regular bathing of patients is not possible. Even under such difficult physical conditions, members of the permanent MEDICO staff are doing a remarkable job both in service and teaching.

"It was extremely satisfying to me to have the opportunity to share even for such a short time in this great humanitarian effort to help prevent needless deaths from curable diseases."

Dr. Hoekenga is director of medical and scientific coordination for the William S. Merrell Company in Cincinnati, prescription pharmaceutical manufacturers.

In commenting on Dr. Hoekenga's experiences, Dr. Charles U. Hauser, Cincinnati Area Committee of MEDICO, urged other physicians to add their own personal support by serving as a MEDICO volunteer overseas or by contributing financially to its operation. Dr. Hauser himself has made several voluntary trips overseas in behalf of MEDICO, and is an assistant executive director in the program.

Additional information about the program may be obtained by writing Dr. Hauser in care of the national office, MEDICO, 660 First Avenue, New York, N. Y. 10016.

The Akron Beacon Journal recently told the dramatic story of Army Captain Robert L. Klein and his successful removal of a live grenade from the leg of a Vietnamese prisoner in Saigon. A resident of Akron, Dr. Klein joined the service last August after receiving his medical degree from Marquette University and finishing a year of internship in Milwaukee.

Dr. Richard L. Fulton is 1968 president, and Dr. Walter Baum, first vice-president, of the Diabetes Association of Central Ohio. Both are of Columbus.

Lectureship in Physical Medicine Honors Cleveland Physician

The first Walter J. Zeiter lecture was delivered on April 25 in Chicago, honoring the director of education at the Cleveland Clinic.

The event was part of the 30th annual meeting of the American Academy of Physical Medicine and Rehabilitation which Dr. Zeiter served as executive director for 20 years, retiring in 1960.

Speaker was Dr. Frank H. Krusen of Tufts-New England Medical Center, Boston, who discussed the "Historical Development in Physical Medicine and Rehabilitation During the Past Forty Years."

In establishing a perpetual lecture fund in the name of Dr. Zeiter, the American Academy of Physical Medicine and Rehabilitation proposes "to honor a physician whose long years of devoted service to the specialty of physical medicine and rehabilitation is recognized by all members of our specialty. His outstanding executive leadership has been a major factor in the development of our medical discipline."

Dr. Zeiter joined the staff of the Cleveland Clinic in 1937 as head of the Department of Physical Medicine and Rehabilitation. He later served as assistant to the executive director of the Clinic and executive secretary of the board of governors. In 1962 Dr. Zeiter assumed his present position as director of education.

Columbus Insurance Executive Dies; Agency Program Will Continue

Floyd L. Turner, Columbus insurance executive of long standing and chairman of the board of Turner & Shepard, Inc., died at the age of 61 on May 11. Mr. Turner was a past president of the Columbus Chapter of Chartered Life Underwriters and of the Mid-America Association of Group Agents. He played leading roles in the business, civic, and fraternal activities of the community.

Mr. Turner was well known to many Ohio physicians through his association with the Turner & Shepard agency, administrators of the group life insurance plan initiated and sponsored by the Ohio State Medical Association and carried by Union Central Life Insurance Company, of Cincinnati.

Arthur E. Shepard, president of Turner & Shepard, Inc., announced that the agency will continue to operate under the same name and will administer the OSMA-sponsored group life insurance plan without interruption. Since 1943 the agency has also administered disability insurance programs for physician members of a number of County Medical Societies in Ohio, and these programs will continue as in the past, Mr. Shepard said.

Officers and AMA Delegates Elected At the 1968 Annual Meeting

DR. THEODORE L. LIGHT, of Dayton, was installed as President of the Ohio State Medical Association at the 1968 Annual Meeting in Cincinnati, May 13-17, succeeding Dr. Robert E. Howard, Cincinnati, who continues on The Council for another year as Immediate Past President. Dr. Light was named President-Elect at the 1967 Annual Meeting in Columbus and was installed as President at the final session of the House of Delegates at this year's meeting.

A native of Dayton, and a specialist in internal medicine, Dr. Light began serving on The Council in 1963 as Councilor of the Second District. He is a Past President of the Montgomery County Medical Society, a former Delegate of that Society to the OSMA House of Delegates, and is now serving as a Delegate of the OSMA to the American Medical Association.

Dr. Robert N. Smith, of Toledo, was named President-Elect and will assume the Presidency at the 1969 Annual Meeting in Columbus. Dr. Smith has served on The Council since 1963 as Councilor of the Fourth District. He is a native of Fulton County, a graduate of the U. S. Military Academy at West Point, and received his medical degree from the University of Nebraska College of Medicine in 1952. He specializes in anesthesiology, is a Fellow of the American College of Anesthesiology and a Diplomate of the American Board of Anesthesiology.

Elected to succeed Dr. Smith as Councilor of the Fourth District is Dr. George N. Bates, also of Toledo. Dr. Bates is a graduate of the Faculty of Medicine of McGill University, Class of 1942. He is a Diplomate of the American Board of Surgery and specializes in general surgery.

The House of Delegates elected Dr. Dwight L. Becker, of Lima, as Councilor of the Third District, to succeed Dr. Frederick T. Merchant, of Marion, who was not a candidate for re-election. Dr. Becker has been active in medical organization work; has served as delegate for Allen County to the OSMA, is a former treasurer of Ohio Medical Indemnity and a member of its Board of Directors. He is a member of the OSMA Committee on Government Medical Care Programs.

Dr. William M. Wells, Newark, has been serving on The Council by appointment to complete part of the unexpired term of Dr. James A. Quinn, Jr., who is practicing in Oklahoma. Dr. Wells was elected by the House of Delegates to complete the remaining year of the unexpired term, as Eighth District Councilor.

Councilors re-elected for additional two-year terms are the following: Dr. Paul N. Ivins, Hamilton, First District; Dr. P. John Robechek, Cleveland, Fifth District; Dr. Sanford Press, Steubenville, Seventh District; Dr. Oscar W. Clarke, Gallipolis, Ninth District; and Dr. William R. Schultz, Wooster, Eleventh District.

Councilors in the midst of two-year terms are the following: Dr. George J. Schroer, Sidney, Second District; Dr. Edwin R. Westbrook, Warren, Sixth District; and Dr. Richard L. Fulton, Columbus, Tenth District.

The following physicians were re-elected Delegates to the AMA: Dr. George W. Petznick, Cleveland; Dr. Carl A. Lincke, Carrollton; Dr. T. L. Light, Dayton; and Dr. Robert E. Tschantz, Canton. Dr. Edmond K. Yantes, Wilmington, was not a candidate for re-election.

Holdover Delegates are Dr. Philip B. Hardymon, Columbus; Dr. John H. Budd, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Frederick P. Osgood, Toledo; and Dr. Charles A. Sebastian, Cincinnati.

Dr. Robert E. Howard was elected an Alternate Delegate to the AMA. Physicians re-elected AMA Alternate Delegates are Dr. Robert S. Martin, Zanesville; Dr. Harry K. Hines, Cincinnati; and Dr. Henry A. Crawford, Cincinnati.

Holdover Alternate Delegates are Dr. Lawrence C. Meredith, Elyria; Dr. P. John Robechek, Cleveland; Dr. Frank F. A. Rawling, Toledo; Dr. Frank H. Mayfield, Cincinnati; and Dr. Robert N. Smith, Toledo.

Because of the time element, only this brief summary of the election is given. Detailed reports, including minutes of the House of Delegates, will be published in the July issue.

Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER*

AN EXCITING three-day and one-evening program is offered to the children of the AMA and Auxiliary members during the AMA Convention in San Francisco June 16 through 19. The activities will be coordinated by a teen committee under auxiliary auspices. Mrs. Fernando Gomez and Mrs. Xavier Barrios are in the "thick" of this particular activity. Tickets will be on sale in the Borgia Room of the St. Francis Hotel (teen headquarters — entrance on Post Street) beginning at 11:00 A. M., Sunday, June 16. Registration fee is $1.00.

Judging from past observations, these pre-teen and teen-ager programs are a boon to parents attending convention. They know their young'uns will be having a good time, under genial, careful "chaperones" and that they will get to see and do interesting things that would probably not otherwise be open to them. I've had the privilege of watching them "coming and going" and a more excited, happier bunch of kids you never did see!

Here's some of the planned doin's: On Monday, June 17, a five-hour excursion by boat and bus. Bus ride to Fisherman's Wharf, boat cruise of San Francisco Bay, disembarking at Tiburon; bus ride to Sausalito, return over Golden Gate Bridge; Tuesday, June 18 — five-hour bus excursion to San Francisco Zoo, Steinhart Aquarium, Japanese Tea Garden; Wednesday, June 19, Walking Tour of Chinatown; includes tour of Fortune Cookie factory, lunch at Four Seas Restaurant; evening of Wednesday, June 19 — Rock Concert, LIGHT Show, Entertainment at San Francisco Medical Society Building; music by the noted Rock Bands, Sons of Champlin and Sal Carson; entertainment by the Marlins; refreshments.

From Mrs. Karl F. Ritter, National President, comes this special word: "A cordial invitation is extended to all members of the Woman's Auxiliary to the American Medical Association, their guests, the wives of AMA delegates, alternates, and international guests, and guests of physicians attending the AMA convention, to participate in all social functions and to attend the general meetings of the Auxiliary . . . please register early and secure badge and program."

*Mrs. Meltzer was named President-Elect of the Auxiliary to OSMA at the Annual Meeting in Cincinnati. New chairman of the Publicity Committee is Mrs. Robert E. Pumphrey, 338 Meadowview Drive, Dayton, Ohio 45459.

Here and There

More than 5,000 junior and senior high school students in **Allen County** have seen the proof which is positive — that sexual promiscuity has a number of dangers, with venereal diseases ranking as potential killers. These teen-agers have heard 45-minute presentations by the Auxiliary in conjunction with the Academy of Medicine and the Allen County Health Department. Mrs. William Noble, chairman of the auxiliary's Community Service Committee in charge of the program, said she has become so involved in the study since last fall and its manifestations on the health and morality of residents that "I sound like a preacher"!

She went on to say "Though it once was a job to do, now I'm terribly involved . . . I worry and hope . . . So far the response has been satisfying and gratifying . . . everywhere we've gone, the kids have looked and listened without a snicker . . . when parents see the film, hear the facts and the statistics, any negation is gone . . ." The auxiliary's emphasis has been a program of education, based on a 16-minute movie, a discussion and then a question and answer period available to all 7th through 12th graders. Two copies of the film "Quarter of a Million Teen-Agers" purchased by the group — the money coming from proceeds of the annual member-husband "bridge-o-rama." The *Lima News* in its Sunday, April 21 edition, gave tremendous coverage to the auxiliary's venereal disease program with the headline "Auxiliary VD Study Aids Youth."

The **Allen County** group had its installation of officers in April at the home of Mrs. Robert Holladay. Mrs. Dwight Becker was installed as president, Mrs. David Barr as president-elect, Mrs. Holladay as vice-president, Mrs. Ronald Bell as secretary and Mrs. Thomas Leech as treasurer. A covered dish luncheon was served, followed by a spring fashion show sponsored by Madison's. Models were Mrs. Maurice Lewis, Mrs. Noble, Mrs. L. W. Like and Mrs. James Baker. It was quite a day for Allen County auxilians — for in the evening of that day, the women were cocktail and dinner guests of the Lima and Allen County Academy of Medicine. This was the first time in the history of the Academy that the Auxiliary had been invited and to top it off, there were orchids for the ladies. Dr. Robert Howard, then OSMA President, Dr. Theodore Light, Incoming OSMA President, and Mrs. Light were the speakers and honored guests.

Other Places

Cuyahoga County members are putting Amy Vanderbilt in the amateur leagues with still more hostessing. These gals seem to be in demand for more functions at more places than Amy herself!) The most recent was at the opening of the new Handi-Hope Chest Shop in the Hotel Statler-Hilton's lobby. Mrs. James N. Wychgel was chairman of the Tea-and-See there on April 7. The auxiliary-sponsored Bargain Boutique Shop in the Fairhill Psychiatric Hospital continues to do a landoffice business. A call has gone out to members for more clothing. The Cleveland Orchestra Rehearsal program on March 6, sponsored by the auxiliary and the orchestra's Women's Committee, was a highly successful musical treat, according to Mrs. Roscoe J. Kennedy, chairman. A profusion of spring flowers together with lovely spring bonnets provided their own muted and dulcet tones at the dessert-coffee hour which preceded the musical program.

"Auxiliary Travels in Style" headlined the picture lay-out in the *Cincinnati Post and Times-Star* of members of the **Hamilton** auxiliary working on the group's benefit fashion show.

The event was held at the Hotel Sheraton-Gibson Roof Garden in March, with Mrs. Albert R. Zoss and Mrs. F. L. Mendez, Jr., serving as cochairman. Described as a "Fashion Travelog," this unusual fashion show demonstrated suitable clothing for a variety of trips. Sponsored by Shillito's, professional models paraded an interesting and practical and beautiful collection of the clothes milady should wear "en route" . . . Emphasis was placed on line, style, and fabrics. Such projects as the Philanthropic Fund which contributes to nursing scholarships, the Apple Tree Nursery, Project Hope and discretionary funds for the deans of the School of Practical Nursing and the U. C. College of Medicine all benefited from this "Travel in Style" program.

Popping Out!

Poppies were blooming all over as "Spring Was Poppying Out All Over" at the annual bridge luncheon of the **Lucas County** auxiliary at the Academy on April 23. Proceeds from the event was earmarked for AMA-ERF. Cochairmen were Mrs. J. R. Yoder and Mrs. Richard V. Alberry. Other committee members included: Mrs. Richard A. Brenner, Mrs. William Eggleston, Mrs. C. K. Parker, Jr., Mrs. George N. Thrailkill, and Mrs. David P. Wheeler.

The ever-active Lucas County women once again sponsored the Volunteer Recognition Luncheon which has been held at the Academy of Medicine for the past 14 years. (They also help in the care of over 1500 Toledo children at the Day Care Centers.) The luncheon was held on April 22 and the highlight of the afternoon was the presentation of an original playlet which Mrs. Howard Smith, Mrs. Daniel Wolff and Mrs. Max Schnitker had presented at last year's auxiliary state convention. Exquisite crowns of flowers were made in honor of the volunteers by the children of the Miami Children's Home. Mrs. R. E. Scherbarth and Mrs. Ward Jenkins served as auxiliary chairman and cochairman, assisted by Mrs. A. J. Kuehn, Metropolitan chairman.

The May 8 luncheon meeting at the Inverness Country Club featured the installation of officers. Mrs. S. L. Meltzer, then state publicity chairman, served as the installing officer, reminding the members that the doctors' wives organized, not because they had to do something, but **because they had something important to do.** "We still have many 'somethings' to do," she commented, adding that the finest leadership, the keenest minds, the most willing and dedicated of officers can only step forward as rapidly as the general membership itself clears that road with "blessed cooperation." The new Lucas County officers include: Mrs. Daniel Wolff, president; Mrs. Joseph Roshe, president-elect; Mrs. Jack Burnheimer, vice-president; Mrs. John Van der Veer, recording secretary; Mrs. Robert Youngen, corresponding secretary; Mrs. Albert J. Tremblay, treasurer; and Mrs. Joseph Westhoven, assistant treasurer. Mrs. James Farkas and Mrs. Roshe headed the luncheon committee. Mrs. Howard Smith, outgoing president, presented a significant annual report.

Mrs. Meltzer, author of the medical novel *Falls The Shadow,* later discussed the dramatic story of the x-ray against the background of which her book was written. She paid tribute to the "unsung heroes," the pioneers in the field of radiology, many of whom gave their lives that humanity might benefit. She told the poignant story of Dr. Emile Grubbe, the man with "half a face." She described the ridicule that was heaped on the "new-fangled contraption" after its discovery by the German physicist, Dr. Wilhelm Conrad Roentgen. *Falls The Shadow* is not a technical novel," she said. "It is written in a simple, almost journalistic style, and is directed at the lay public who, for too many years, looked upon the x-ray specialist as someone who was not a 'real doctor.' "

A Salute!

The **Sandusky County** auxiliary recently celebrated its 20th anniversary with a recognition evening at the home of one of its charter members, Mrs. Frank Moore. Mrs. W. L. Damschroder, president, presided and called upon the group's past presidents to tell of humorous incidents recalled from their year in office. This brought back to life such things as selling boxes of candy in a blinding storm from the back of a member's car on Election Night and rummage sales at which "we bought and exchanged more than we sold" . . . They dwelled on

such accomplishments as the Sabin Clinic which they cosponsored with the Medical Society, sponsoring the drive to purchase TV sets for the county home, purchasing equipment for the Nurses' Home and Memorial Hospital, supporting the hospital building fund, camperships for two boys and two girls, and starting the bingo parties for patients at the Oak Ridge Sanatorium back in 1952. Members have also been called in emergencies, as in 1959 when they spent an entire day and night cooking and serving meals to flood victims.

China, symbolic of a 20th anniversary, was distributed among the charter members in the form of individual dishes made by Mrs. Ed Kramer and inscribed with the name and dates of the organization. Sharing the special moments with the Sandusky women were Mrs. Benjamin Gillette, former past state president, who helped to organize the group; Mrs. Malachi W. Sloan, state president-elect; Mrs. Ward Jenkins, state district director. Assisting the hostess, Mrs. Moore, were: Mrs. C. D. Miller and Mrs. R. A. Shurmer, cochairmen; Mrs. R. A. Eyestone, Mrs. J. C. Bates, Mrs. W. W. Randolph, Mrs. W. J. Martin, Mrs. C. J. Wolf, Mrs. L. A. Pokerr and Mrs. Harold Keiser. *The Fremont News-Messenger* featured the anniversary event with tremendous coverage and picture layouts. A special door prize was won by Mrs. Crede Hiestand and the "20th year-old picture contest" had two winners — Mrs. Helen Huber and Mrs. John Monahan.

Newly installed president of the Scioto County auxiliary is Mrs. William E. Daehler. The 1968-69 officers were installed by Mrs. B. U. Howland, a past president and district director, at the group's annual May Breakfast at Harold's Restaurant. Mrs. Howland gave a significant talk on "Hands," likening the auxiliary membership to the close working of each finger of the hand, one with the other, each dependent upon the other, to work efficiently. Installed with Mrs. Daehler were: Mrs. Alden B. Oakes, vice-president; Mrs. Richard Villarreal, president-elect; Mrs. Jack MacDonald, secretary; Mrs. Donald Appleton, treasurer, and Mrs. James Scott, historian. Serving as hostesses at this May Breakfast were: Mrs. T. G. McCormick, Mrs. L. B. Hatch, Mrs. J. P. McAfee, Mrs. Philip Weems and Mrs. Dow Allard.

Travel Notes

COME! To California, but of course — and that incredible Ohio Breakfast which really is something . . .

Columbus Administrator Named President-Elect of OHA

Bernard J. Lachner, administrator of the University Hospitals at Ohio State University, was named president-elect of the Ohio Hospital Association at its annual meeting in Cleveland.

Lachner is a member of the Board of Trustees of the statewide organization for hospital employees and last year served as first vice-president of the group.

Along with his position as University Hospital administrator, Lachner is assistant dean for budget and fiscal affairs in the College of Medicine and professor of hospital and health service administration in the School of Allied Medical Professions.

Other officers of the Ohio Hospital Association are: President, Lloyd E. Larrick, M.D., administrator of Christ Hospital, Cincinnati; first vice-president, Sister Grace Marie, Good Samaritan Hospital, Cincinnati; second vice-president, Howard Taylor, director, Aultman Hospital, Canton; treasurer, John F. Latcham, Trumbull County Memorial Hospital, Warren; trustee at large, Jim Hughes, attorney, Columbus.



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MEMBER: *American Hospital Association — National Association of Private Psychiatric Hospitals — Ohio Hospital Association*

County Societies' Officers and Meeting Dates

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High Street

ADAMS—Gary J. Greenlee, President, Farmers' National Bank, Manchester 45144; Hazel L. Sproull, Secretary, Box 337, West Union 45693. 3rd Thursday, January, April, July, and October.

BROWN—Philip A. Pealzgraf, President, 1830 Ohio Pike, Route 1, Batavia 45103; Robert S. Benintendi, Secretary, 117 West Cherry Street, Georgetown 45121. Meetings monthly.

BUTLER—Walter H. Roehill, Jr., President, 701 North University Boulevard, Middletown 45042; Mr. E. Clifford Roberts, Executive Secretary, 110 North Third Street, Hamilton 45011 4th Wednesday monthly.

CLERMONT—G. Franklin Lowe, President, Cemetery Road, Milford 45150; Raymond L. Davidson, Secretary, 684 Batavia Pike, Cincinnati 45245. 3rd Wednesday monthly.

CLINTON—David Hamilton, President, 615 West Main Street, Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Stanley D. Simon, President, 708 Doctors Building, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday monthly.

HIGHLAND—Thomas L. Jones, President, 528 South Street, Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson Street, Greenfield 45123.

WARREN—George A. Rourke, President, 210 Mound Street, Lebanon 45036; Ray E. Simendinger, Secretary, 901 North Broadway, Lebanon 45036. 2nd Tuesday monthly.

Second District

Councilor: George J. Schroer, Sidney 45367
322 Second Ave.

CHAMPAIGN—Stephen V. Rader, President, 113 Miami Street, Urbana 43078; T. Grogan, Secretary, 848 Scioto Street, Urbana 43078. 2nd Wednesday monthly.

CLARK—Martin J. Cook, President, 1054 East High Street, Springfield 45505; Mrs. Marion L. Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone Street, Springfield, Ohio 45503. 3rd Monday monthly.

DARKE—Ross M. Zeller, President, 414 Walnut Street, Greenville 45331; Giles Wolverton, Secretary, Health Department, Court House, Greenville 45331. 3rd Tuesday monthly.

GREENE—Cary B. Gardner, President, 1182 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly, except July and August.

MIAMI—John Gallagher, President, 145 Sunset Drive, Piqua 45356; Al C. Howell, Secretary, 6650 Tipp-Cowlesville Road, Tipp City 45371. 1st Tuesday monthly.

MONTGOMERY—Peter A. Granson, President, 1100 South Main Street, Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly.

PREBLE—J. D. Darrow, President, 228 North Barron Street, Eaton 45320; J. R. Williams, Secretary, 401 North Barron Street, Eaton 45320.

SHELBY—George J. Schroer, President, 322 Second Avenue, Sidney 45365; Alfonsas Kisielius, Secretary,Ohio Building, Sidney 45365. Meetings every three months.

Third District

Councilor: Frederick T. Merchant, Marion 43302
1051 Harding Memorial Pky.

ALLEN—Nathan Kalb, 904 Cook Tower, Lima 45801; T. E. Bilon, Secretary, 908 Cook Tower, Lima 45801. 3rd Tuesday monthly.

AUGLAIZE—Herbert Wolfe, President, Box 238, New Knoxville 45871; Dale Kile, Secretary, 112 Court Street, Saint Marys 45885. 1st Thursday every other month.

CRAWFORD—Charles E. Skinner, President, 211 South Boston Street, Galion 44833; Donald E. Widman, Secretary, X-Ray Department, Galion Community Hospital, Galion 44833.

HANCOCK—Reid Burson, President, Arlington 45814; Carlson Cochran, Secretary, 1725 South Main Street, Findlay 45840. 3rd Tuesday monthly.

HARDIN—Walter W. Stoll, Jr., President, 900 East Franklin Street, Kenton 43326; Robert A. Thomas, Secretary, Mount Victory 43340. 2nd Tuesday monthly.

LOGAN—Glen E. Miller, President, Route 2, West Liberty 43357; Donald Wyse, Secretary, Route 2, West Liberty 43357. 1st Friday monthly.

MARION—Robert E. Logsdon, President, 250 Executive Drive, Marion 43302; Walter R. Schuler, Secretary, 399 East Church Street, Marion 43302. 1st Tuesday monthly.

MERCER—Richard Dobbins, President, 119 East Fayette Street, Celina 45822; Don Schwieterman, Secretary, Rolfes Road, Maria Stein 45860. 3rd Thursday monthly.

SENECA—O. G. Burkart, President, 19 East Perry Street, Tiffin 44883; Leroy J. Cummings, Secretary, 455 West Market Street, Tiffin 44883. 3rd Tuesday every other month.

VAN WERT—Jack H. Cox, President, Medical Arts Building, Fox Road, Van Wert 45891; Edward E. White, Secretary, 704 East Central Avenue, Van Wert 45891.

WYANDOT—H. A. Rhodes, President, 777 North Sandusky Avenue, Upper Sandusky 43351; D. P. Smith, Secretary, Sycamore 44882. 2nd Tuesday monthly (luncheon meeting).

Fourth District

Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

DEFIANCE—Carlos R. Diaz, President, 1132 East Second Street, Defiance 43512; Wm. S. Busteed, Secretary, Box 218, Defiance 43512. 1st Saturday A. M. monthly.

FULTON—F. E. Elliott, President, 203 Beech Street, Wauseon 43567; R. L. Davis, Secretary, 137 South Fulton Street, Wauseon 43567. 2nd Tuesday, March, June, September, and December.

HENRY—T. F. Moriarity, President, 651 Strong Street, Napoleon 43545; W. J. Stough, Secretary, 515 Avon Place, Napoleon 43545.

LUCAS—J. S. Kozy, President, 3672 Rugby Drive, Toledo 43614; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Boulevard, Toledo 43610. 3rd Tuesday monthly, except July and August.

OTTAWA—Robert W. Minick, President, Port Clinton Road, Oak Harbor 43449; H. A. Boker, Secretary, 113 Columbus, Lakeside 43440. 2nd Thursday monthly.

PAULDING—Richard D. Stagg, President, Merrin and Laura Streets, Payne 45880; Kirkwood A. Pritchard, Secretary, 119 South Main Street, Paulding 45879. Called meetings.

PUTNAM—James B. Overmeir, President, 109 Main Street, Leipsic 45856; Arthur P. Daniel, Secretary, 144 North Walnut Street, Ottawa 45875. 1st Tuesday monthly.

SANDUSKY—E. C. Hiestand, President, Old Fort 44861; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.

WILLIAMS—N. T. Levenson, President, Central Drive, Bryan 43506; P. G. Meckstroth, Secretary, Central Drive, Bryan 43506. 3rd Tuesday monthly.

WOOD—Gerald G. Woods, President, 513 Superior Street, Rossford 43460; L. J. Eulberg, Secretary, Pemberville 43450. 3rd Thursday monthly.

Fifth District

Councilor: P. John Robechek, Cleveland 44106
10525 Carnegie Ave.

ASHTABULA—Z. O. Sherwood, President, 254 South Broadway, Geneva 44041; Mrs. Carol M. Kifer, Executive Secretary, P. O. Box 475, Ashtabula. 2nd Tuesday monthly.

CUYAHOGA—Elden C. Weckesser, President, 10465 Carnegie Avenue, Cleveland 44106; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106. Board of Directors meets 2nd Tuesday monthly.

GEAUGA—Arturo Dimaculangan, President, Geauga Medical Park, 13241 Ravenna Road, Chardon 44024; Mrs. Martha S. Withrow, Executive Secretary, P. O. Box 249, Chardon 44024. 2nd Friday monthly.

LAKE—Carl G. Madsen, Jr., President, 168 East High Street, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening, bimonthly, except June, July, and August. (January, March, May, September, and November.)

Sixth District

Councilor: Edwin R. Westbrook, Warren 44481
438 North Park Ave.

COLUMBIANA—J. Fraser Jackson, President, 205 West Sixth Street, East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Avenue, Salem 44460. 3rd Tuesday monthly.

MAHONING—Robert R. Fisher, President, 3718 Market Street, Youngstown 44507; Mr. Howard C. Rempes, Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44504. 3rd Tuesday monthly.

PORTAGE—Louis V. Castaldi, President, 444 South Meridian Street, Ravenna 44266; Miss Marie Motyka, 430 Grant Street, Akron 44311. 3rd Tuesday monthly.

STARK—Wm. D. Baker, President, 1696 South Arch Street, Alliance 44601; Mr. J. H. Austin, Executive Secretary, 505 4th Street, N. W., Canton 44702. 2nd Thursday monthly.

SUMMIT—D. W. Mathias, President, 819 First National Tower, Akron 44308; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 1st Tuesday monthly.

TRUMBULL—Donn F. Covert, President, 200 Garfield Drive, N. E., Warren 44483; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday monthly.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth Street

BELMONT—E. V. Arbaugh, Jr., President, 414 Jefferson Street, Martins Ferry 43935; Bertha M. Joseph, Secretary, 100 South Fourth Street, Martins Ferry 43935. 3rd Thursday, except January, May, July, and August.

CARROLL—C. H. Dowell, President, 103 West Main Street, Carrollton 44615; T. J. Atchison, Secretary, 292 East Main Street, Carrollton 44615. 1st Thursday monthly.

COSHOCTON—Don Potts, President, 600 East Main Street, West Lafayette 43845; H. W. Lear, Secretary, 133 South Fourth Street, Coshocton 43812. 2nd Tuesday monthly.

HARRISON—Charles Evans, President, 159 South Main Street, Cadiz 43907; C. E. Vorhies, Secretary, Scio 43988. Quarterly, March, June, September, and December.

JEFFERSON—Geary M. Eicher, Jr., President, St. John Hospital, Steubenville 43952; Francis A. Sunseri, Secretary, 703 North Fourth Street, Steubenville 43952. 4th Tuesday monthly.

MONROE—Byron Cillespie, Secretary, Woodsfield, Ohio 43793.

TUSCARAWAS—Thomas E. Ogden, President, 146 East Main Street, Gnadenhutten 44629; Efrain Padro, Secretary, 200 West 2nd Street, Dover 44622. Four meetings a year minimum. Generally held 2nd Thursday of month or a preceding Wednesday dinner meeting.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson

ATHENS—Philip Kinnard, President, 7 Hooper Street, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. 2nd Tuesday noon, except July and August.

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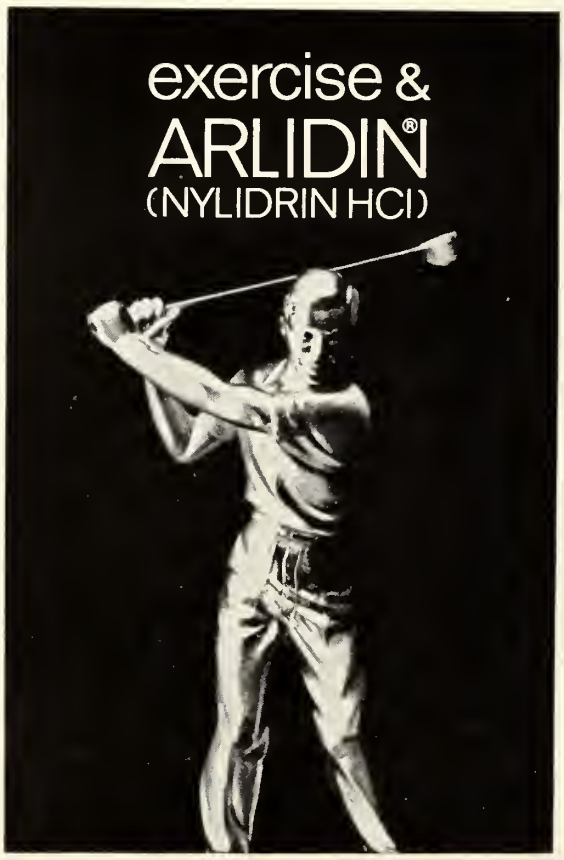
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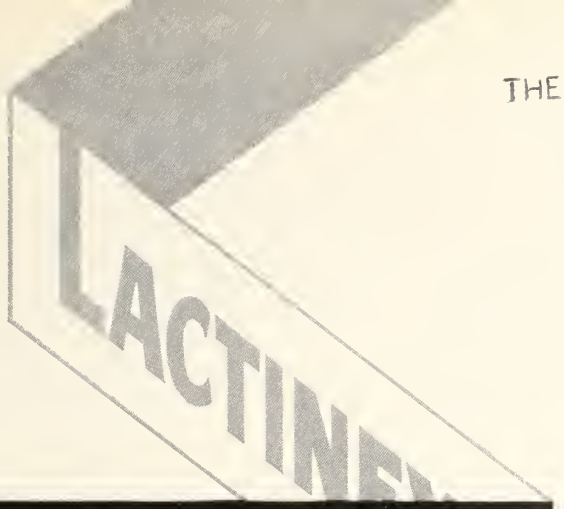
Indications: Infections susceptible to oral penicillin G; prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, staphylococcal and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity. Bronchial asthma or other allergies. Resuscitative (epinephrine, vasopressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be immediately available. Other rare hypersensitivity reactions include eosinophilia, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units). Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

potassium phenoxymethyl penicillin) Wyeth

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LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,[1,2,3,4] LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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The OHIO STATE MEDICAL Journal

VOL. 64 JULY, 1968 No. 7

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Address All Correspondence:
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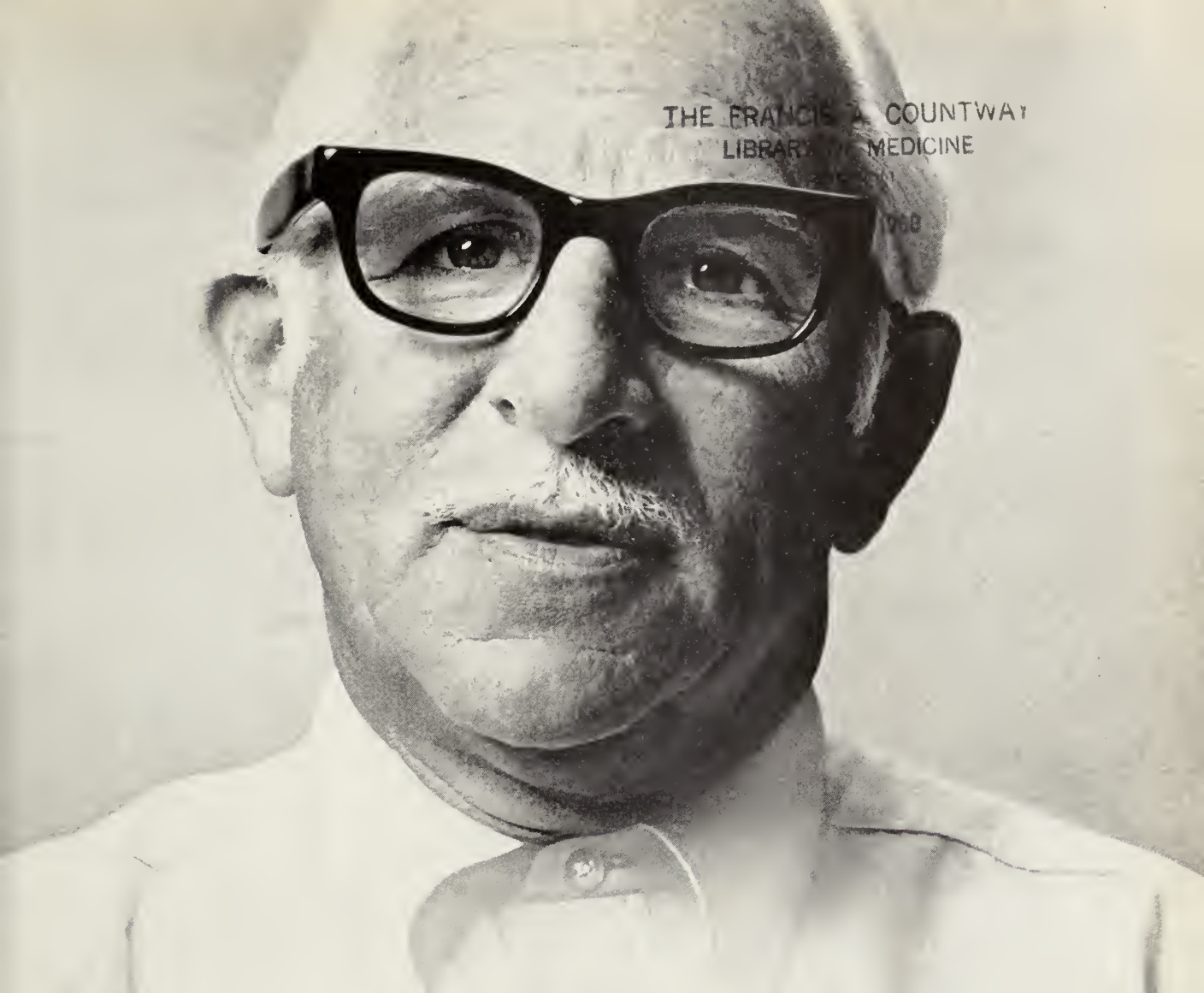
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He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

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b.i.d.

guard susceptible patients against intestinal monilial overwth during broad-spectrum therapy—the protection of statin is combined with demethylchlortetracycline in CLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN ne broad-spectrum therapy that prevents monilial rgrowth.

traindication: History of hypersensitivity to demethylchlortetracye or nystatin.

ning: In renal impairment, usual doses may lead to excessive accumuon and liver toxicity. Under such conditions, lower than usual doses indicated, and, if therapy is prolonged, serum level determinations be advisable. A photodynamic reaction to natural or artificial sunt has been observed. Small amounts of drug and short exposure may duce an exaggerated sunburn reaction which may range from erytna to severe skin manifestations. In a smaller proportion, photo-gic reactions have been reported. Patients should avoid direct osure to sunlight and discontinue drug at the first evidence of skin omfort. Necessary subsequent courses of treatment with tetracyes should be carefully observed.

autions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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24-68

National Health Institutes Seeking Certain Patients

The cooperation of physicians is requested in the referral of patients with certain types of ailments for continuing studies being conducted within branches of the National Institutes of Health.

Following are specific categories of patients specified in recent communications and physicians to be contacted:

* * *

Patients with Ewing's Sarcoma are needed for continuing study conducted by the Radiation Branch of the National Cancer Institute; patients who have received no treatment are preferred, but selected patients with previous therapy will also be accepted for admission as inpatients.

Physicians interested in having their patients considered for admission to this study may write or telephone: Ralph E. Johnson, M.D., Clinical Center, Room B1B-41B, National Institutes of Health, Bethesda, Maryland 20014; Telephone: 496-5457 (Area Code 301).

* * *

Patients with chronic myelogenous leukemia are needed. Patients of all ages with high white blood cell counts and platelet counts are needed for studies of newer chemotherapeutic agents and as a source of white cells and platelets for in vitro and in vivo study.

Write or telephone: George P. Canellos, M.D., Clinical Center, Room 12N236, National Institutes of Health, Bethesda, Maryland 20014; Telephone: 496-4916 (Area Code 301).

* * *

A study of cardiac function in patients with a severe pectus excavatum chest wall deformity is being conducted by the National Heart Institute. Referrals would be appreciated of any patient between 16 and 30 years of age who has a severe pectus excavatum deformity and who complains of excessive fatigue and exertional dyspnea.

Write or telephone: Dr. Stephen Epstein, Clinical Center, Room 7-B-14, National Institutes of Health, Bethesda, Maryland 20014; Telephone: 496-3015 (Area Code 301).

Cleveland Clinic Foundation Offers Course in Gastroenterology

The Cleveland Clinic Educational Foundation is offering a postgraduate course in "gastroenterology" on Wednesday and Thursday, November 6 and 7 at the clinic. Related medical motion pictures will be shown on Tuesday evening preceding the program.

Inquiries on this and other clinic courses are invited and may be directed to Walter J. Zeiter, M. D., Director of Education, Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

HARDING HOSPITAL

(Formerly Harding Sanitarium)

WORTHINGTON, OHIO

For the Diagnosis and Treatment of Psychiatric Disorders and with Limited Facilities for the Aging

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Open-eyed nights





Too tense to sleep...too tired to get up. Early to bed, late to rise, and not much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

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Valium®(diazepam)

useful for the relief of psychic tension, alone or with associated depressive symptoms



Cleveland Physician Accepts Post in Pittsburgh

Dr. Robert A. Hingson announced that he will become professor of public health practice at the University of Pittsburgh July 1.

He also will be professor of anesthesiology at the University of Pittsburgh Schools of Medicine and Dentistry and director of his specialty at Magee Hospital.

In Cleveland he has held, and will leave, similar positions at University Hospitals and Case Western Reserve University medical school.

In the past few years Dr. Hingson has been engaged in world-wide public health services and returned in May after several weeks in Central America.

There he received a Maximus Hero Medal for taking $600,000 worth of measles vaccine into Honduras and arranging for the vaccination of 100,000 people in a week.

Dr. Hingson founded and is president of the Brother's Brother Foundation, which is supported by many Clevelanders and will continue here under Dr. Hingson's attention. He will expand the organization to Pittsburgh. The Foundation finances public health undertakings in this and other countries. It is an interfaith, interracial service organization.—Cleveland Press

* * *

Dr. Hingson was further honored with the Religious Heritage of America citation at the 18th annual meeting in Washington, D. C. for his work in improving health standards in underdeveloped nations.

Medical Aspects of Sports Conference Announced

The Tenth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Miami Beach, Florida, at the Hotel Deauville on December 1. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

Featured luncheon speaker will be Payton Jordan, Head Coach of the 1968 U. S. Olympic Track and Field Team, who will discuss "The Olympics in Retrospect."

The Conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

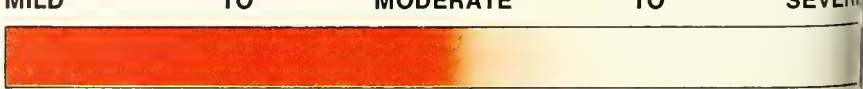
Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

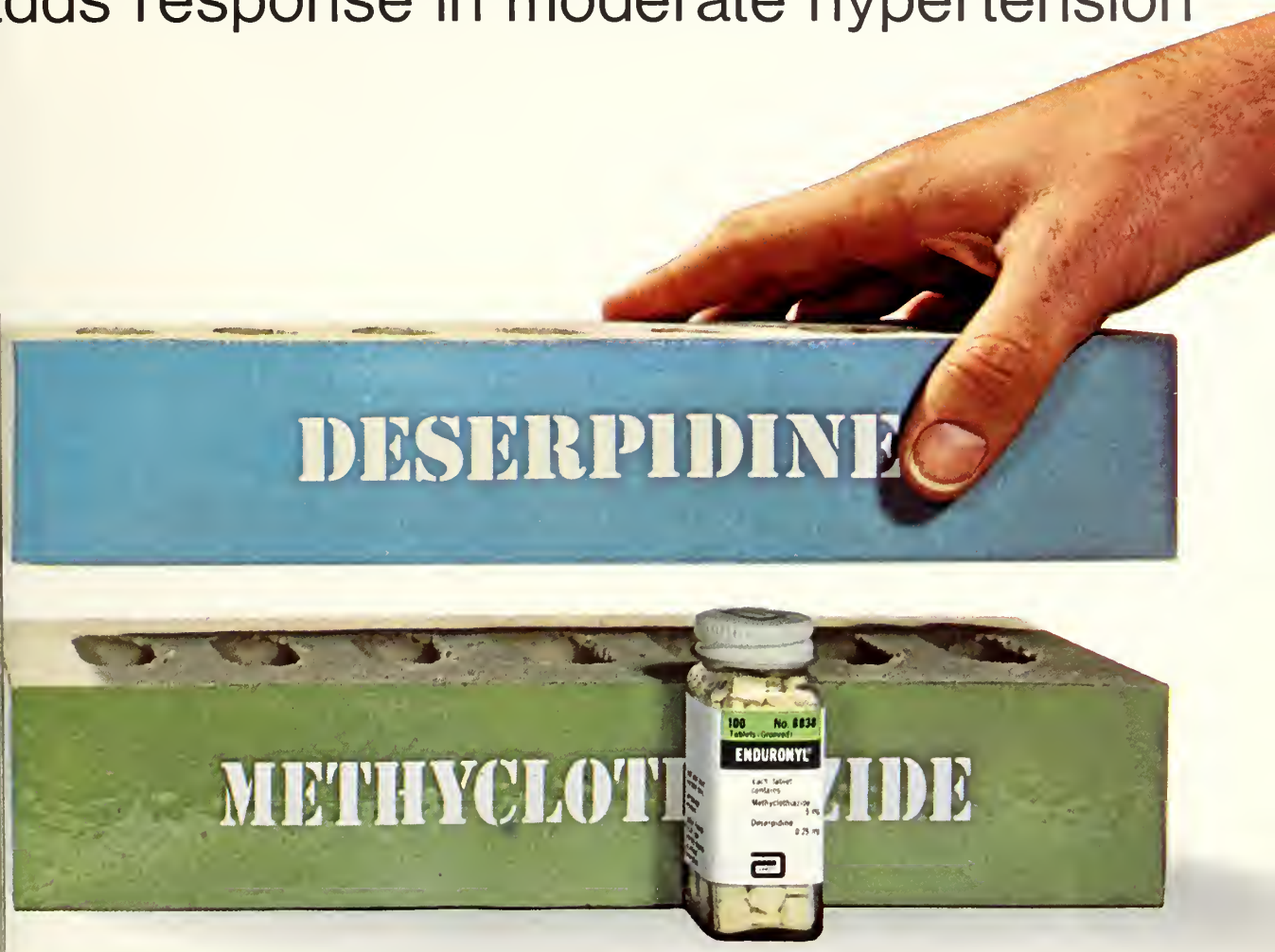
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

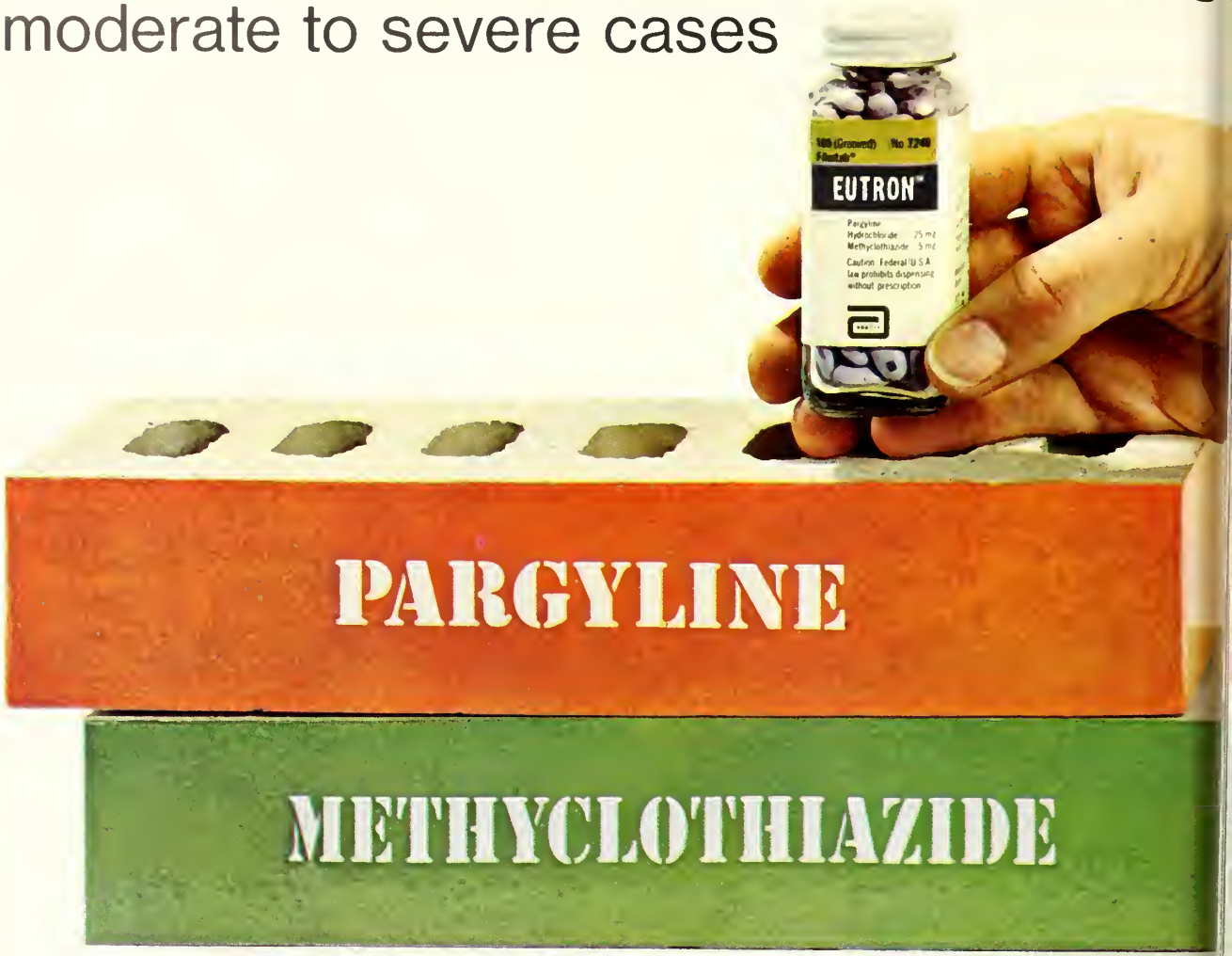
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

8010

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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The Historian's Notebook

Medicine in Fairfield County, Ohio, 1800-1850

By CHESTER P. SWETT, M. D., Lancaster, Ohio

PART III

(Concluded from June Issue)

DR. H. H. WAIT

One reference spelled the surname as Whaite. He came to Lancaster about 1827 from Virginia, since in that year he was granted a license to practice by the Thirteenth District Medical Society. Within a few years, he was a busy practitioner. He was a large man with an impressive personality. His practice grew to the proportions of that of either Dr. McNeill or Dr. White as the returns of his income for taxation show. Sometime before 1850, he terminated his medical career here and moved to a town in the Scioto Valley where he died.

DR. JOHN MILTON BIGELOW

Dr. Bigelow was recorded previously as having been nominated to receive a course of lectures gratis at the University of Cincinnati in 1829. One year later he passed an examination held by the Thirteenth District Medical Society. He opened an office in Lancaster and enjoyed a busy practice for many years. He married a sister of Mrs. William Phelan and raised a large family. His interests were not wholly confined to medicine. He was a scholar with a keen and active mind and made a hobby of botany. In the capacity as a botanist he was a member of the U. S. Commission that established the Mexican boundary after the Mexican War. Sometime after 1850 he moved to Detroit. His appointment to this commission may well have been a gesture of friendship from a fellow townsman and colleague, Dr. Tom O. Edwards who was a member of Congress then.

DR. PAUL CARPENTER

This honorable and respected practitioner was born in Lancaster, Pa., in 1810. At the age of 18 he came to Lancaster, Ohio, and taught school for three years. During that time he studied medicine with Dr. Robert McNeill as his preceptor. The next year he graduated from the Ohio Medical College in Cincinnati and was admitted to membership in the Thirteenth District Medical Society, May 29, 1832. This being accomplished he opened an office in Lancaster. He was a prominent member of the Masonic Lodge and of the Methodist Church. His wife, Mary, whose maiden name is unknown, died at the early age of 27. He married a second time. There are the graves of six children in the Carpenter lot in Elmwood Cemetery. Four children died in infancy. A daughter Laura Augusta died in 1870 at the age of 21. The only child to live beyond that age was Henry W. Carpenter 1834-1914. Dr. Carpenter died in 1880, being 70 years old at his death.

GEORGE WASHINGTON BOERSTLER, SR., M. B.

Another prominent physician who achieved lasting honors and distinction was Dr. George W. Boerstler. He moved to Lancaster from Hagerstown, Md., probably in 1834 or 1835. He was the son of Dr. Christian Boerstler who was born in 1750 and reared in Germany where he married and practiced for a few years. One source states that George was born in Funkstown, Md., in 1792. George was a bright boy and his father planned to have him study for the Lutheran ministry. The young man reluctantly began the course of study.

He soon informed his father of his dislike for this calling and of his desire to study medicine. His father became his preceptor and later enrolled him in the University of Maryland. In 1820, he graduated with honors with a degree of Bachelor of Medicine. He had already married Elizabeth Links before he entered college. After graduation he first practiced in Boonesboro, Md., and later in Hagerstown. When he came to Lancaster he was accompanied by his wife, daughter and a newly acquired son-in-law, Dr. Tom O. Edwards. The two opened offices in partnership. In December 1835, Dr. McNeill died, which event

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"Nothing else I've tried seems to work, so I decided to give you a crack at it."

caused his large practice to scatter to other doctors in town.

Drs. Boerstler and Edwards soon established a satisfactory practice and became solid and enterprising citizens. Dr. Boerstler busied himself also with local civic and political activities. When General Andrew Jackson died in 1845, he was the Chief Marshall at the local obsequies held for the ex-President. In the same year, he made a patriotic address to the Fairfield County Militia anticipating the Mexican War. He was a member of the Whig party and a pro-slave advocate, and later became a Democrat and made political speeches. In 1851, he traveled to Cincinnati and delivered an address in German at a reception for the Hungarian patriot, Louis Kossuth.

His first wife died in 1838. A few years later he married Elizabeth Schur. To this union three daughters and one son were born. The latter was Dr. George W. Boerstler, Jr., who studied medicine at Wooster College, and practiced in Lancaster for many years.

Dr. Boerstler, Sr., became interested in medical organization and attended medical meetings in Columbus and elsewhere in the State. In this way, his ability and talents became recognized. An indication of the respect for his leadership and personality in medical circles is attested by the fact that he was elected the first President of the Ohio State Medical Society when it was organized in 1846. His residence was listed in some records of the Association as Findlay, Ohio. However, this is an error, since he was a resident of Lancaster from his arrival until his death. Again in 1851, he was elected to the Presidency of the Society, an added emphasis to his capabilities and inspiration. He continued to conduct an active practice almost until his death in 1871. Dr. Loving of Columbus in a paper written after Dr. Boerstler's death referred to him as an able and learned physician, who was wise in counsel.

DR. TOM O. EDWARDS

This enterprising son-in-law of Dr. Boerstler was born in Maryland and received his medical education there. After marrying Miss Boerstler he practiced in Hagerstown, and later accompanied his father-in-law when he moved to Ohio. With the development of his practice he too became interested in politics and in 1840 he stumped for the Whigs. His office on Main Street became a headquarters for local political conferences and became known as the "Coon Box." He was very popular, sociable, polite, well known, and entertaining.

Elected to Congress

His political activity and his ability as a public speaker caused the party to induce him to run for Congress. He was elected and served for one term, 1847 and 1848. He soon occupied a very respectable position in that legislative body. He introduced a bill in the interest of pure drugs, and this bill and his speech in support of it gave him some reputation. Among the distinguished members of Congress in 1848 were ex-President John Quincy Adams and Abraham Lincoln. Dr. Edwards was present in the House when the ex-President was stricken with paralysis, and he was the physician who attended him during the two days that he lived. Both he and Mr. Lincoln were members of the committee that escorted the body to Quincy, Massachusetts. At this time, he was a very popular politician in his home town. He made good speeches and was a brilliant conversationalist and a recognized leader.

Business Lures Him

After completing his term in Congress, he was induced by a Boston firm to manage a drug store in Cincinnati. He became quite prominent in local politics in that city, was elected to the City Council, and, by the Council was made its President. Not long after this he was appointed to the faculty of the Ohio Medical College.

With all of this in his favor he still managed to become a failure in the field of business. At the end of five years he gave up the business venture and moved first to Madison, Wisconsin, then to Dubuque, Iowa. Later he returned to Lancaster to again practice medicine. When Senator Thomas Ewing died in 1871, Dr. Edwards was one of the honorary pallbearers. Later he retired from practice and spent his last days at the home of his son in Wheeling.

MICHAEL EFFINGER, M. D.

About 1842 Dr. Effinger opened an office for the practice of medicine in Lancaster. He was one of the first if not the first physician here who was a native son. He was born in 1819, the son of Samuel and Mary Noble Effinger. His father came to Lancaster in 1813. His grandfather, Samuel Noble came from Maryland and settled on a farm near Tarleton. His mother was a sister of Colonel John Noble. He attended the schools and Academy of Lancaster and entered Miami University, where he graduated with honors. He then studied medicine under the preceptors, Drs. Boerstler and Edwards. This exposure to the medical art quickened his interest so much that he matriculated in the College of Medicine of the University of Pennsylvania. After earning the degree of Doctor of Medicine he returned to Lancaster to hang out his shingle.

His Marriage and Career

His father had died in 1832 bequeating a respectable estate to his widow. Included was a very nice home which Samuel had built in 1818. It was of a Georgian Paragon style. Dr. Effinger resided there with his mother. In 1846, he married Elmira Catlin,

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BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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a niece of Darius Tallmadge. A boyhood friend of the groom was chosen as best man at the wedding. Continued rains for several days rendered the roads muddy and flooded. The stage coaches were delayed. The time for the wedding arrived but the best man was absent. A brother of the groom was pressed into service as the "second" best man. Just as the ceremony was concluded, the first best man stomped into the house, his boots covered with mud and his clothing dripping from the rain. It was Lieutenant William T. Sherman. This dashing young officer rushed to the bride, pushed away the groom, and claimed the first kiss from the new bride. Dr. Effinger and General Sherman were friends until death parted them many years later.

Dr. Effinger took his bride to his mother's home, which stood on the site now occupied by the Hotel Lancaster. He practiced nearly 50 years and was a leader in civic, social, and medical circles. In his home were entertained such national figures as Henry Clay, General Grant, Salmon P. Chase, Daniel Webster, and many others.

Resumé

A resumé of the first half century of medicine in this county is a fitting conclusion. The first doctors were men certainly with a flair for adventure. Some were rather old by the standards of the day. Yet, they apparently were dissatisfied with their location, their practice, and perhaps even with themselves. A trip of several hundred miles with rude means of transportation was no deterrent. They had not been accustomed to a sheltered and elegant life. Their origins lay in Vermont and Connecticut of the New England States, a few from Pennsylvania, more from Maryland and Virginia. Not many were of German origin, although many settlers of that nationality came to this county, the majority from Pennsylvania. Some pursued interests outside of their profession such as civic, political, religious, and social. Nearly all of them contributed significantly in the growth and development of their communities. It should be a source of pride to the medical profession that so many of these men received marks of respect and approval from their contemporaries. Their abilities as leaders and men of judgment and probity caused them to be selected to positions of honor and trust. Their unusual talents and intellect in some instances were recognized not only locally but throughout the State. These men contributed much to the social, political, and economic as well as to the medical life of the new community.

Their Medical Skill

These men had about the average amount of training in medicine prevalent at that time. Most of them had served preceptorships and read medicine. A very few were fortunate enough to receive medical degrees. There are scientists in the field of medicine now who declaim that the results of medical treatment prior to the 20th century were worthless. If the aim of the practice of medicine is only to cure, then this belief might have some basis. While marvelous cures are being achieved at present, there are a number of diseases whose course inexorably leads to death. However, doctors treat these diseases and incidentally treat the patients. These people receive much relief from their suffering by the ministrations of their medical attendant. It is a cruel thought that none of the people who were ill through the centuries should have been treated simply because no cure was available.

The doctors of one hundred years or more ago faced, in cases of pneumonia, meningitis, etc., the same discouraging prognosis as doctors do nowadays with cancer and leukemia. Yet in such instances, physicians aimed to relieve some of the suffering whenever possible. Such a goal is worthy of the finest commendation. The physician does not promise a cure even today. The credo of the medical man was probably best expressed in a brief and simple philosophy by Ambroise Paré whose aim was "to cure sometimes, to relieve often, to comfort always."

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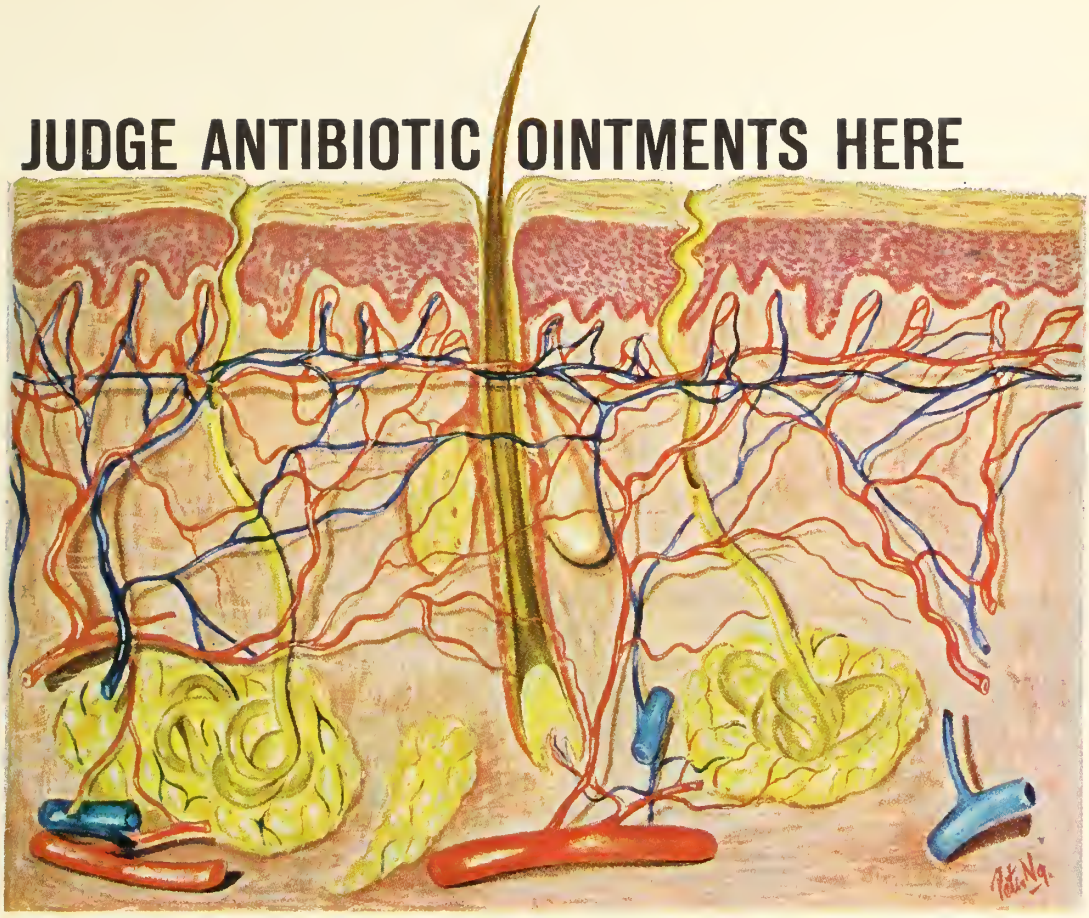


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Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

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Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the dr should be discontinued.
2. Liver function tests must be performed at regular intervals during t ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated live dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tono etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause ey changes.
4. Complete urinalysis and BUN should be done on patients treated Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocyto eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities liver function tests, cholestatic and hepatocellular jaundice, urinary fr quency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the ur impotence, disturbances of coordination, confusion, headache, fatigu blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis an paresthesias, depression with agitation, talkativeness, nystagmus, tin- nitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrom photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, eryt multiforme and nodosum, aggravation of disseminated lupus erythema tosus, gastric distress, abdominal pain, diarrhea, constipation, anore dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps conjunctivitis, left ventricular failure, aggravation of hypertension, hyp tension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular e are drug-related is not known. However, some of these complications resulted in fatalities.) The necessity for discontinuing the drug should dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with me if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the should be increased in one-half tablet (100 mg.) increments every 12 h until freedom from pain is achieved. To relieve pain, between 200 mg. 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patien with a dose of 400 mg. to 800 mg. daily. Maintenance doses may rang between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-
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Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

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chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

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Life of Hiram's Dr. Harry Hurd Memorialized in New Book

A newspaper article in the *Record Courier,* of Ravenna, relates the background for a new book entitled *The Way of This General Practitioner.* The book is based on the life of Dr. Harry C. Hurd, practitioner of long standing at Hiram and is written by his widow, Dalla Hurd.

A passage from the article reads: "But the book is more than a biography of a locally loved and respected country doctor. Divided into three sections, the first is alive with turn-of-the-century life in Portage County and Hiram. The second part consists almost entirely of Dr. Hurd's diary entries during his years as a medical officer in a Red Cross Commission which fought typhus, dysentery, diphtheria, eye diseases, social problems, sanitation problems, and even legal problems in the Middle East following World War I.

"The third section of the book is devoted to the return to Hiram of Dr. Harry, of his practice during the thirties and forties . . . "

Dr. Hurd was born on December 24, 1874, graduated from Miami Medical School, Cincinnati, in 1902, and died on January 16, 1961. Among his contributions to organized medicine, he was president of the Portage County Medical Society in 1929.

The book may be purchased through the Hiram College Book Store, Hiram, Ohio.

New Estimates Are Announced on Prevalence of Arthritis

New survey figures which put the number of people in the U. S. suffering some form of arthritis at 16,800,000 are revealed in the 20th Anniversary annual report (1967) of The Arthritis Foundation, recently published.

This is an increase of more than 3,000,000 over previous estimates of the country's arthritis population.

Since the total population of the country is more than 200,000,000, it means that one in 11 people have arthritis. The old figure was one in 16.

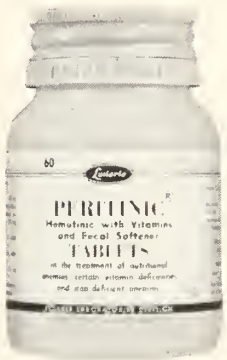
The new arthritis prevalence estimate resulted from a National Health Interview Survey conducted in 1966-67 by the U. S. Public Health Service's National Center for Health Statistics. Among other statistics cited in the report:

An estimated 3,400,000 arthritis victims are disabled — limited in their usual activities — at any one time.

Including annual wage losses and medical care costs due to arthritis, the total annual cost to the national economy is estimated at more than $3.5 billion.

The total 1968 national investment in research and training against arthritis is estimated at $15,000,000.

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OSU Research Team Examines Teenage Smoking Habits

Researchers in Ohio State University's Department of Preventive Medicine expect to shed some light soon on the "social cues" which induce teenagers to smoke.

The cues and other facts on the prevalence and causes of teenage smoking are anticipated as findings from an investigation of 5,500 teens ranging from the seventh to 12th grade.

The Ohio Department of Health initiated the research and awarded a grant to the Franklin County Health Department to study the problem. Members of the Division of Community Health of the University's Preventive Medicine Department, under the direction of Dr. Martin Keller, are cooperating with the two agencies in carrying out the study. They interviewed and examined the teenagers, who were from the Southwestern School District, Grove City, near Columbus.

The first step of the survey involved a comprehensive questionnaire designed to gather information on the social and educational background of each child as well as on smoking patterns.

The teenagers who completed the questionnaire were assured that their answers would be kept confidential. About 5,500 questionnaires were returned.

Out of the 5,500, all boys from ninth through 12th grades were given physical examinations, including a breathing test to determine lung function. Results of the examinations should clearly indicate the extent of physiological difference between smoking and nonsmoking boys, the researchers believe.

After physicals were completed, a group of about 350 boys and girls of all age groups were questioned individually.

Physician Named Head of National Office of MEDICO Office

Dr. Colgate Phillips, an internist of Glens Falls, N. Y., has been named head of MEDICO, a service of CARE, it was announced by Frank L. Goffio, executive director of the international aid agency.

Dr. Phillips, on leave of absence from his practice, joined MEDICO in May, 1967, and had been serving as team captain of its medical installation in Kabul, Afghanistan.

As assistant executive director of CARE in charge of MEDICO, Dr. Phillips will supervise the work of 43 physicians, nurses, and technicians serving two-year assignments in six nations of Asia, Africa, and Latin America. He will also be responsible for the volunteer program, in which an average of 110 specialists each year pay their own travel and living expenses on month-long visits to MEDICO posts, practicing and teaching their specialties.

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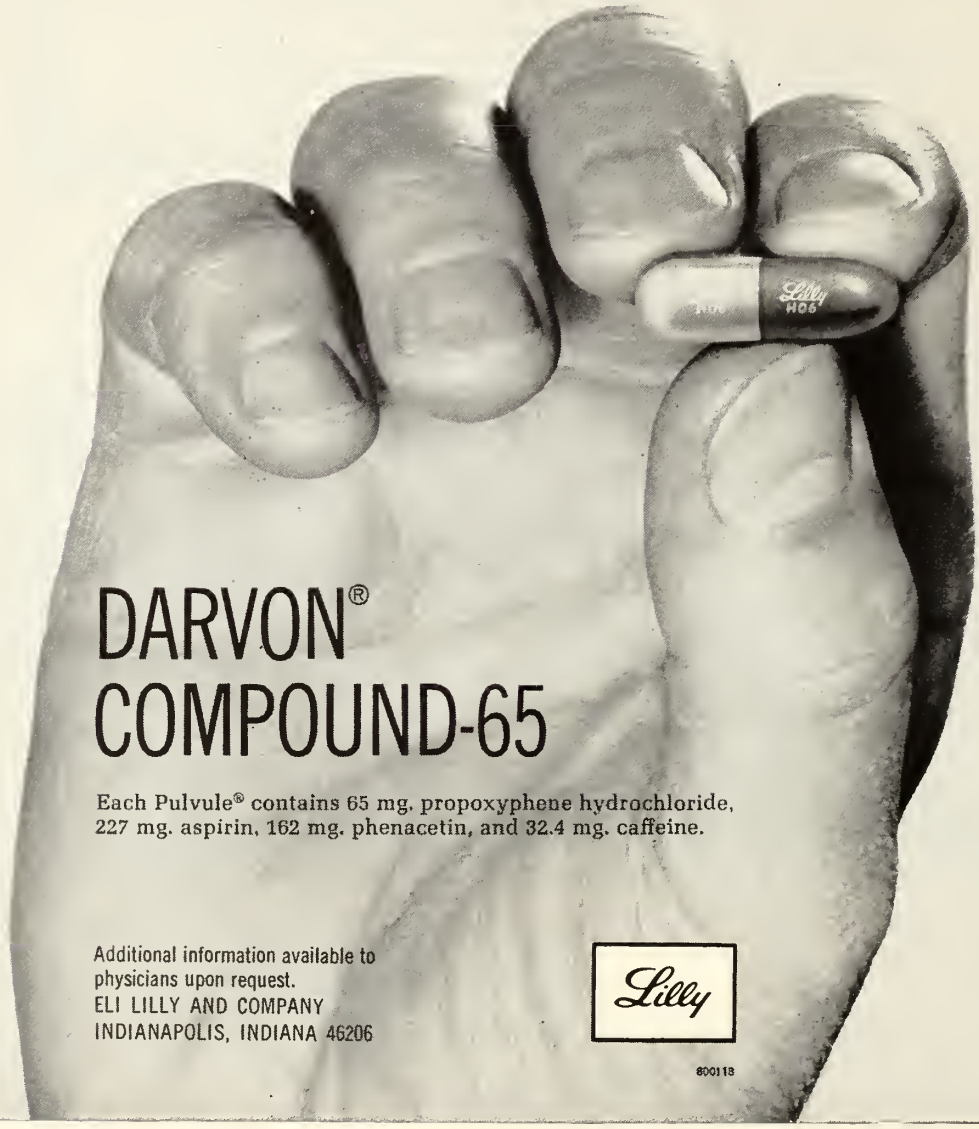
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Scientific Section

VOL. 64 JULY, 1968 NO. 7

Major Hepatic Resection

CHARLES MARKS, M.D.

IN 1898 Langenbusch[7] recorded the first case of liver resection and by the following year, in reporting a personal case of liver resection Keen[6] was able to collect 76 cases of similar partial resections for hepatic tumors and drew attention to the capacity of the residual liver to maintain good function. It was not until 1911, however, that the first case of right hepatic lobectomy was documented.[16] In a symposium on liver resections recorded in the proceedings of the Royal Society of Medicine in 1923, Grey-Turner,[15] Francau,[3] and Wright[17] described hepatic resections for malignant disease; yet by 1944, when Pickrell and Clay[11] reported on three cases of hepatic lobectomy, a review of the literature emphasized the infrequency of this operation. Within the last decade great impetus has been given to the procedure of hepatic lobectomy by the work of Brunschwig,[1] Pack,[10] and Quattelbaum[12] in America, and Lloyd Davies[8] and Rodney Smith[13] in England. Greater appreciation of the segmental anatomy of the liver has been a contributory factor in this regard added to improvements in diagnostic technics and greater appreciation of postoperative metabolic problems.

Segmental Anatomy of the Liver

The anatomic studies of Cantlie[2] and of McIndoe and Counsellor[9] have long since demonstrated the error of the old descriptive anatomy of the liver in which the organ was thought to be divided into right and left lobes by the falciform ligament, the sagittal fossa, and the ligamentum venosum.

The new anatomic concepts have been refined by corrosion cast studies of Hjortsjo[5] and of Healey and Schroy.[4] These studies have indicated that the correct division between right and left hepatic lobes is formed by a lobar fissure which extends from the medial edge of the gallbladder fossa inferiorly to the bare area adjacent to the inferior venae cava superiorly. Each lobe is further divided into two segments by a fissure. The right lobe is thus subdivided into an anterior and posterior segment, and the left lobe has a segmental fissure corresponding in situation to the falciform ligament on the parietal surface and the ligamentum venosum superiorly, creating a medial and lateral segment (Fig. 1).

The medial segment of the left lobe thus corresponds to what was previously described as the quadrate lobe, the lateral segment representing the old description of the left liver lobe. The caudate lobe consists of a median caudate process between a right and left segment.

Each segment has its own segmental hepatic artery, portal vein radicle, and bile duct, providing safe sites for surgical incision. The hepatic veins, however, do have intersegmental branches requiring appropriate surgical control. Each of the four main segments are further subdivided by appropriately placed fissures into a superior and inferior area, each having its own area artery and bile duct. The subareas of

Submitted December 11, 1967.

The Author

● Dr. Marks, Cleveland, is Associate Clinical Professor of Surgery, Case Western Reserve University School of Medicine and Director, Division of Surgery, Mount Sinai Hospital of Cleveland.

the left medial segment each have two arteries and bile ducts. In the caudate lobe a single artery supplies the area incorporating the median process and right segment and another artery supplies the left segment. Each of these three segments, however, has its own separate bile duct.

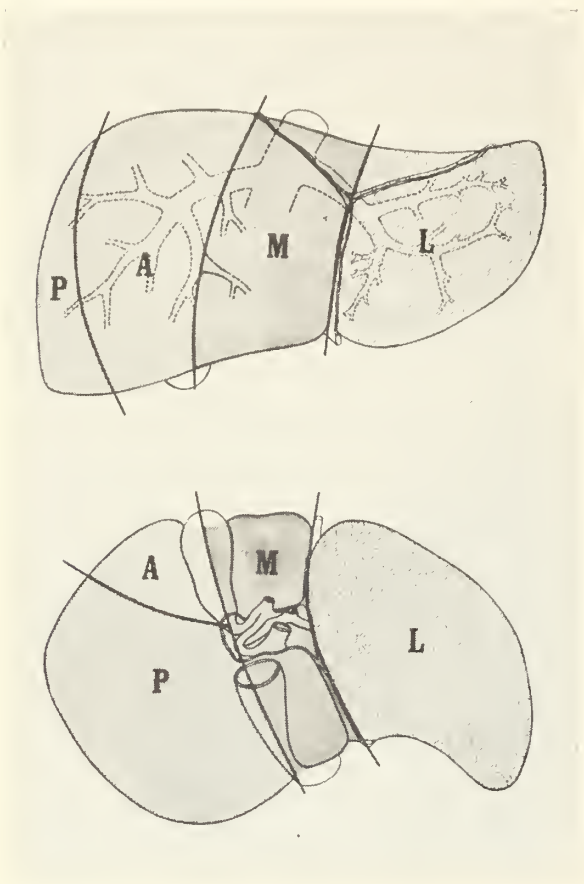


FIG. 1. *Major Segmental Divisions of Liver:*
A Anterior segment of right lobe
P Posterior segment of right lobe
M Medial segment of left lobe
L Lateral segment of left lobe

Technic of Hepatic Lobectomy

Adequate access to the right lobe is absolutely essential and may be obtained by an ample thoracoabdominal incision traversing the eighth intercostal space with division of the diaphragm. For a right hepatic lobectomy the patient is positioned with a 45 degree tilt to the left and the right arm flexed at the elbow, being elevated and supported at the clavicular level. For a left hepatic lobectomy, a long, high, transverse abdominal incision provides good access to the porta hepatis for ligation of the vessels and bile ducts to the left lobe.

In carrying out a right hepatic lobectomy it is important that dissection of the cystic duct and cystic artery permits ligation and division of these structures followed by dissection, ligation, and division of the right hepatic artery, the right hepatic duct, and the right branches of the portal vein, these being ligated with 2-0 silk before division. Division of the triangular ligament, the coronary ligament, and any of the peritoneal bands between the dome of the liver and diaphragm permits mobilization of the liver in preparation for partial hepatectomy.

Incision of Glisson's capsule provides a plane of cleavage for anatomic lobectomy by blunt dissection and the intersegmental veins may then be visualized and ligated before their division, though the use of the cautery in cutting through the liver tissue is equally permissible. If it is thought that sustained total hepatic inflow control will be necessary before resection can proceed, the use of general body hypothermia is advisable in order to protect the liver from the effects of hypoxia. A temperature of 30 C should then be attained. Additional control of hemorrhage may be obtained with the use of overlapping mattress sutures.



FIG. 2. *Cholangiogram demonstrates size of liver abcess cavity.*

Diagnostic Technics

The definition of intrahepatic disease may require identification of the distorted portal venous, hepatic arterial, or intrahepatic bile duct apparatus; and ac-

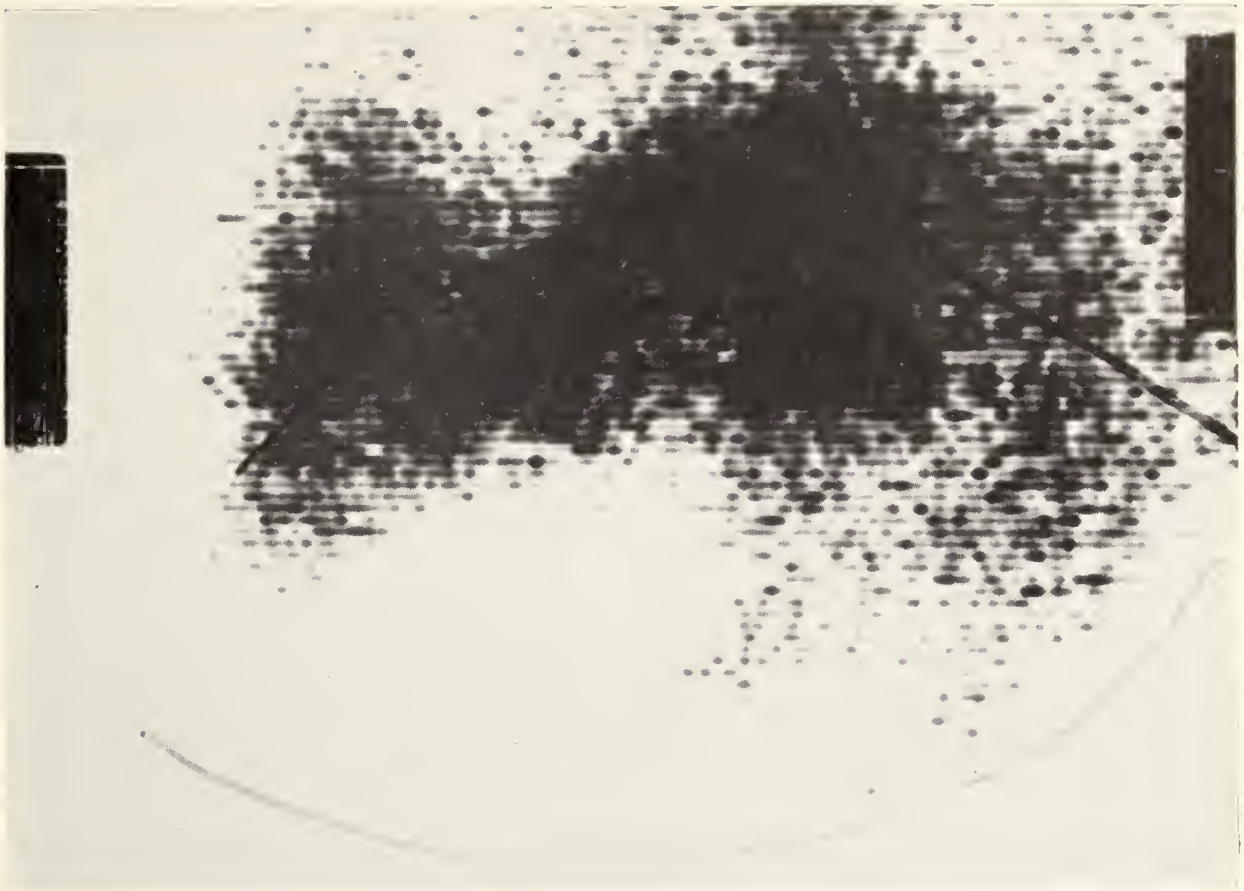


FIG. 3. *Extensive malignant hepatoma demonstrated by liver scan.*

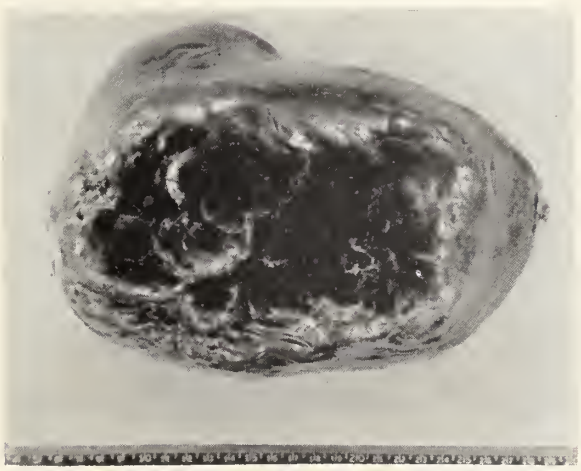


FIG. 4. *Resected right liver lobe with localized malignant hepatoma.*

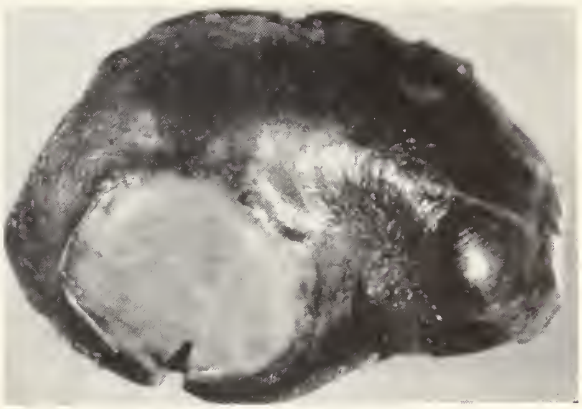


FIG. 5. *Resected hepatoma within left lobe of liver.*

cordingly, splenoportography, transaortic hepatic arteriography, and cholangiography may all help define an abscess cavity, a hematoma-filled cavity associated with hemobilia, or the presence of neoplasm. (Fig. 2).

Liver Scanning

The administration of rose bengal tagged with I^{131} utilizing the technic of Taplin et al,[14] permits scintiscanning of the liver from ten to 60 minutes after the intravenous administration of five microcuries per kgm. of body weight. Absorptive defects in the liver, whether due to granuloma, cyst or neoplasm, will be indicated by areas of diminished uptake, representing encroachment by the nonfunctioning pathologic tissue on the normally functioning area (Fig. 3).

Clinical Material

In the four year period, 1963 to 1967, formal major hepatic resection has been carried out in ten patients. In four patients, this was done as a result of acute hepatic trauma. In a fifth patient this was performed as a delayed operation for persisting hemobilia attributable to the development of a large intrahepatic hematoma consequent to previous injury. In one case, the indication for resection was a chronic abscess involving the whole of the right lobe of the liver, and in four patients, the indication was malignant disease of the liver. In one of these patients, the primary hepatoma was confined to the right lobe of the liver (Fig. 4), and, in another patient, it was confined to the left lobe of the liver (Fig. 5). In two patients, segmental resection of the lateral segment of the left lobe was performed in the course of gastric resection for carcinoma of the stomach. Two operative deaths in this group of cases provides an operative mortality of 28 per cent. The remaining patients all recovered satisfactorily from the operation and have done well.

In reviewing the nature of the two deaths, the first represented an elderly patient with a previous myocardial infarction who was undergoing Myleran® therapy for multiple myeloma. At emergency laparotomy the patient was found to have sustained a severe laceration of the right hepatic lobe and sutures failed to control massive bleeding. Right hepatic lobectomy had to be performed and the patient died on the third postoperative day after the development of renal failure.

The second death was in a patient suffering from a large hepatic abscess who should have been presented for hepatic lobectomy at a much earlier stage in the disease process. Conservative surgical and antibiotic management had continued over a three month period, during which time the effects of chronic sepsis complicated by empyema of the right chest reduced this patient's capacity to withstand the formidable procedure sbsequently necessary.

Although wedge excision of adjacent liver parenchyma has been performed on several occasions during cholecystectomy for infiltrating carcinoma of the gallbladder, we have not to date carried out a formal hepatic lobectomy for this condition.

The capacity of the liver parenchyma to regenerate after a right hepatic lobectomy is starkly obvious in a patient who underwent a total right hepatic lobectomy for hepatoma. A postoperative liver scan in this patient, six months later, demonstrated the degree



FIG. 6. *Liver scan three months postoperatively demonstrates extent of liver regeneration.*

of regenerative capacity which extended into the resected area (Fig. 6).

CONCLUSION

Appreciation of the segmental anatomy of the liver provides a sound basis for development of the technic of segmental or lobar resection of the liver. Accurate diagnosis of the extent of liver involvement by the disease process is possible by the use of radiologic and radioactive liver scan procedures. There is little doubt that increasing experience with the technical problems involved, as well as improved understanding of the subsequent metabolic derangement that may occur after major liver resection, will provide added safety in its performance and in the survival of patients requiring this formidable surgery.

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THE CARDIAC SURGICAL TEAM. — A review of the present status of operations on the heart would not be complete with a discussion only of the diseases, technics and machinery. The persons involved are of the essence. They require the ability and opportunity to be molded into a team. Cardiac surgery is thus inherently a task for a medical center, where sufficient clinical material is available for this team to maintain skill and efficiency. Anesthesiologist, cardiologist, surgical and general nurses, technician, engineer, social worker and others, as well as the surgeon and his assistants, each holds a key post. The cardiac surgeon plays a major part, but even with the training, hard work and discipline that he must master, he is but a leader and not a soloist. Members of the surgical team are repeatedly challenged intellectually, physically and spiritually. Their goal is not only the perfection and advancement of their skill but principally, through these, as in all branches of medicine, to transmit charity[1,2] to the patient. In the performance of cardiac operations, surgical technic reaches its zenith — care, gentleness, steadiness, calmness, stamina and honesty are attributes to be continuously cultivated. Dwight C. McGoon, M. D., Rochester, Minn.: *The New England Journal of Medicine,* 278:194-198, January 25, 1968.

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Stinging Insect Allergy

A Discussion of Diagnosis and Treatment

JAMES I. TENNENBAUM, M. D.

A STING by an insect of the order *Hymenoptera:* bees, yellow jackets, wasps, and hornets — may be fatal. An analysis of deaths due to venomous animals in the United States revealed that 228 deaths were due to *Hymenoptera* stings, almost twice as many deaths as those due to poisonous snake and spider bites.[7] Since the information was obtained from death certificates, summer deaths attributed to other causes such as cardiovascular disease and sunstroke may well have been due to insect sting allergy. Over 70 per cent of these deaths occurred less than one hour after the sting, thus emphasizing the emergency nature of this clinical problem.

The vast majority of serious reactions following insect stings are on an immunologic basis. Antigens present in the venom and body of *Hymenoptera* insects sensitize the patient by an initial sting or inhalation of the breakdown products of the insects. A subsequent sting results in an antigen-antibody reaction which causes the release of histamine and other chemical mediators of an allergic reaction. It has been shown that venom contains one or more whole body antigens besides specific venom antigens.[4,6] In addition, certain whole body antigens of the bee, wasp, and yellow jacket cross-react with each other.[1,4] Therefore, the sting of any one of these insects may induce sensitivity to any of the others.

Symptoms

The clinical manifestations in the sensitive patient are those of an immediate type allergic reaction and may be either local or systemic in nature. The immediate local type reaction consists of severe swelling, redness, and warmth at the site of the sting which may last for several hours or up to several days. The immediate type of systemic reaction is similar to anaphylactic reactions caused by drugs and serums. Such reactions may consist of acute anaphylactic shock, generalized urticaria and angio-edema, asthma, and respiratory distress caused by edema of larynx, trachea, and bronchial tree. In addition, dizziness, nausea, vomiting, and abdominal cramps may occur. A severe systemic reaction may occur with or without local swelling. In some patients, local reactions may progress to involve systemic responses following subsequent stings. Allergic reactions, either local or systemic, usually begin within minutes after the sting and may progress rapidly. The shorter the interval after the sting that symptoms occur, the more severe the symptoms are likely to be.

Several important characteristics of the insect-sensitive patient have been emphasized.[3] (1) Severe reactions may occur at any age, although there is a tendency for a reaction to be more severe in patients over the age of 30. (2) Atopy is not a prerequisite for allergic reactions. In a recent survey, only 27 per cent of persons with insects sting allergy had a personal history of atopy. (3) The severity of a reaction cannot be predicted. Over 50 per cent of patients with severe systemic reactions had no previous unusual reaction.

Diagnosis

As there is no laboratory procedure that can make the diagnosis, a *careful medical history is the keystone to making the diagnosis.* Skin testing, either by the scratch or intracutaneous methods cannot be used as *the only* guide in deciding which patient needs treatment and which patient does not. It is not uncommon for a patient with unequivocal insect sting allergy to have negative scratch and intracutaneous tests. It has been reported that there is no statistical difference in positive skin tests between insect-sensitive patients and noninsect-sensitive controls.[8] The chief value of skin testing is to determine the reactivity of the patient and to decide at which concentration to start therapy. A word of caution — testing must be done with care in patients who are exquisitely sensitive. Anaphylaxis has been reported with a test extract of a 1:1,000,000 dilution.[5] Any physician

The Author

● Dr. Tennenbaum, Columbus, is Assistant Professor of Medicine, Division of Allergy, Ohio State University College of Medicine; a member of the Attending Staff, Ohio State University Hospitals; the Courtesy Staff, Children's Hospital, Columbus; and a Consultant at Veterans Administration Hospital and Wright-Patterson Air Force Base Hospital, Dayton.

Submitted April 24, 1968.

who performs skin testing must be prepared to treat an acute systemic reaction.

Treatment

A. Symptomatic Therapy

1. *Local reactions* are treated symptomatically. Local application of ice may be helpful in reducing the edema and pain. Antihistamines are used for pruritus, and aspirin and codeine for control of intense pain. If conservative management does not control a severe local reaction, a short course of a systemic corticosteroid may be helpful.

2. *A systemic reaction* should be treated by emergency measures! As patients are most apt to be stung away from immediate medical care, the insect-sting-sensitive patient should be instructed in the use of an emergency treatment kit containing a preloaded syringe of 0.3 ml. of a 1:1000 Adrenalin,® an antihistamine, and a tourniquet. If the patient is reluctant to inject himself, he should carry an oral antihistamine pill and ephedrine at all times. If stung, the patient should take both pills and immediately seek medical care.

An insect-sensitive patient should be instructed on the immediate removal of the stinger if stung by a bee. Care should be taken not to squeeze the stinger as more venom may be squeezed into the site. The stinger is best removed by a quick scrape with the fingernail.

Treatment of an acute reaction by the physician is the same as treatment for anaphylaxis due to other causes. Epinephrine 1:1000 is the drug of choice. If shock is present, parenteral fluids with Neosynephrine® or levarteronol may be necessary. If cyanosis or upper airway obstruction are present, oxygen and a tracheostomy may be necessary. Intravenous antihistamines and corticosteroids are of little value in the immediate management of a severe systemic reaction, as the outcome of the reaction will usually have been decided by the time these agents exert any beneficial effect. Following successful treatment of an acute reaction, the patient must be followed carefully for several days. Barnhard recently reported that death from insect stings can occur several hours to days after the successful treatment of the acute reaction.[2] These occurred primarily in patients who had not been hyposensitized.

B. Specific Therapy

Hyposensitization is indicated in every patient who has had a systemic allergic reaction from an insect sting. In addition, patients who exhibit extremely large local reactions should also be hyposensitized, as many of these patients progress to the development of systemic reactions. The decision to treat is not made upon the results of the skin tests but must be based entirely on clinical judgment. As previously noted, skin tests are used mainly as a guide for the starting dose of therapy.

A recent survey by the Insect Allergy Committee of the American Academy of Allergy has indicated that hyposensitization is unequivocally beneficial in decreasing the severity of the reaction to a subsequent sting.[3] Ninety per cent of patients who received an adequate course of hyposensitization experienced a less severe reaction when re-stung. When not hyposensitized, 65 per cent of the patients had progressively more severe reactions. In light of our present knowledge, if a patient experienced a severe systemic reaction, treatment should be given indefinitely as recommended by the Insect Allergy Committee.[7] For less severe reactions most workers recommend a minimum of three to five years of therapy. Because of cross-reactive antigens, treatment should be given with a mixture of bee, hornet, wasp, and yellow jacket antigens. The reader is referred to any good textbook on allergy for the details of hyposensitization.

C. Avoidance

The absolute prevention of a systemic reaction to an insect sting is to avoid being stung. Flowers, flowering trees, and shrubs should be avoided. *Hymenoptera* are attracted to bright colored clothes and floral prints. Therefore, white or lightly colored clothing should be worn. Various perfumes, hair sprays, suntan lotions and other scented preparations attract insects and should not be used. Insect-sensitive patients should not walk outdoors barefooted. Short-sleeved shirts and shorts should not be worn outdoors so that the amount of skin exposure is minimized. An insecticide bomb should be kept in the glove compartment of the car for use should stinging insects fly into the car. Gardening should be done very cautiously, if at all.

Summary

Allergic reactions to *Hymenoptera* insect stings are not uncommon and may even be fatal. Allergic reactions may be either local or systemic in nature. The diagnosis of insect sting allergy is made by a careful medical history. Many patients who have severe systemic reactions have them without previous warning. The best treatment is avoidance. If a systemic reaction occurs, the best treatment is epinephrine. Hyposensitization is effective in lessening the intensity of reactions to re-stings.

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Permanent Cardiac Pacemakers

Six Years of Experience in the Treatment of 95 Patients

CHARLES V. MECKSTROTH, M.D.

Prior to the advent of electrical pacing of the heart, the patient with complete heart block was generally doomed to a life of attacks of increasing frequency of syncope, weakness, and unconsciousness with termination by sudden death. Electrical pacing of the animal heart was carried out by Hyman in 1932, but Zoll, Chardack, and Kantrowitz brought about its practical application.[1-4] Although this remedy for heart block seems simple, its application, namely, supplying a very low voltage to the ventricular myocardium for a fraction of a second for several years, has been accompanied by many engineering and surgical problems.

During the period from December, 1961 to December, 1967, 95 patients have been treated for heart block by various surgical procedures at Ohio State University Hospital.* This number includes five patients who had the initial placement done elsewhere and who were admitted for complications or elective change of the power generator. A left thoracotomy was initially performed upon 42 patients with fixation of the myocardial leads to the surface of the left ventricle. The power generator was implanted in a subcutaneous pocket made through a separate incision in the skin of the left lower quadrant of the abdominal wall. Thirty-three of this group were treated with a fixed rate model and nine were treated by a synchronous pacer which required an additional pick-up lead attached to the left atrium.

Since September, 1965, a thoracotomy has not been used primarily in the treatment of these patients. The electrical lead connecting the permanent endocardiac electrode is inserted, under local anesthesia, into the external jugular vein and is guided to the apex of the right ventricle. The power generator is implanted subcutaneously through a separate incision below the right clavicle. Fifty-three patients were treated initially by this technic.

From the Division of Thoracic Surgery, the Ohio State University Hospitals. Submitted January 12, 1968.

*In addition to the author, surgery on these patients was carried out by Drs. Karl P. Klassen, Howard D. Sirak, James W. Kilman, and John S. Vasko.

The Author

● **Dr. Meckstroth, Columbus, is Associate Professor of Surgery, Division of Thoracic Surgery, The Ohio State University College of Medicine; a member of the Attending Staff, University Hospital, the Active Staff, Mt. Carmel Hospital, and the Courtesy Staffs, Riverside Methodist, Children's, and St. Anthony Hospitals.**

Indications

All patients exhibited complete heart block preoperatively, and in the vast majority, the heart block was permanent. Practically all were initially admitted to the Cardiology or Medical Service, where evaluation was performed and the decision was made to pace the patient permanently. Most of the patients in this report were initially paced temporarily with an external, intravenous catheter to ascertain their need for and to predict their response to permanent pacing. Usually this was accomplished one to seven days before permanent implantation. This report does not include numerous patients who were treated with this temporary pacing catheter for one to three weeks in the treatment of short-term heart block or other arrhythmias.

Methods

From December, 1961 to September, 1965, all patients were subjected to a left thoracotomy and a left lower quadrant abdominal incision, the electrode wire being guided from one incision to the other by a subcutaneous tunnel. The electrodes themselves were fastened by multiple sutures to the surface of the left ventricle, being careful not to injure the coronary arteries. The disadvantages of this procedure were those of a thoracotomy in general and that of lead breakage from multiple flexion at the costal margin.

The introduction of a blunt endocardiac catheter electrode for permanent pacing has now made thora-

cotomy and general anesthesia usually unnecessary. A venotomy is made into the right external or internal jugular vein, and the electrode wire is inserted into it. Under fluoroscopic control, the tip electrode is gently wedged into the muscular folds in the apex of the right ventricle. Intracardiac electrocardiograms are taken simultaneously from the proximal and distal electrodes. An injury current should be obtained from the distal electrode reflecting myocardial contact. The threshold of stimulation of the myocardium should be below 2.5 ma. The electrode wire is passed subcutaneously either anterior or posterior to the clavicle and is brought out in a previously made incision below the clavicle. The power generator is joined to the electrode catheter and this in turn is placed in a subcutaneous pocket made below the infraclavicular incision. Figures 1 and 2 show the incision and the roentgenogram following implantation.

Results

Of these 95 patients, 57 per cent of the thoraco-abdominal type (24 patients) and 75 per cent of the endocardiac type (40 patients) experienced an excellent result (Table 1). That is, the pacemaker was implanted, capture of the impulse was accomplished, and the patient was discharged to return only for routine postoperative visits and eventual elective replacement of the power generator at the prescribed time. Many patients experienced a dramatic response. Not only were Stokes-Adams attacks abolished, which in itself gave the patients increased confidence, but generalized weakness and tiredness were much improved. In those instances where congestive heart failure was present preoperatively, pacemaker implantation made control of failure much easier or abolished it completely. Three patients classified as having an excellent result have died from nonrelated illnesses, one from an arrhythmia and two from carcinoma, of the lung and neck respectively. Five patients in this series were initially treated elsewhere and upon admission required emergency change of power generator (three patients), emergency increase in power generator (one patient), and elective change of power generator (one patient). Following treatment at this institution, their course has been excellent.

A good result has been experienced in 26 per cent (11 patients) of the thoraco-abdominal and 25 per cent (13 patients) of the endocardiac type patients. Additional procedures were required on these patients including readjustment of electrodes or power generator, premature replacement of power generator, repair of broken wire, and/or change from the thoraco-abdominal type to the endocardial type or vise versa. In other words, more than the original implantation procedure was required to maintain relief of heart block. Six patients initially treated with an endocardial electrode eventually required a thoraco-abdominal type: two instances each of myocardial perforation, failure to pace, and infection-erosion. Two patients initially treated with a thoraco-abdominal type required an endocardial system. This was because of multiple wire breakage problems.



FIG. 1. *The power generator is implanted in the pocket formed subcutaneously below the infraclavicular incision. The electrode wire is inserted into the external jugular vein through the supraclavicular incision.*

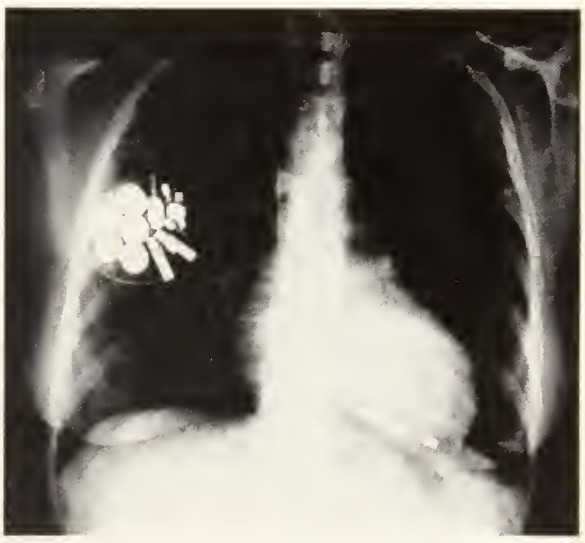


FIG. 2. *Roentgenogram showing the power generator overlying the right chest with the endocardiac catheter electrode in the apex of the right ventricle.*

Four patients in this series died two to 30 months after discharge, from causes unrelated to the pacemaker.

Six of the 20 patients required one adjustment in the electronic system, including replacement of the electrodes in one, removal of the electrodes in one, increasing the amplitude of power generator in two, and repositioning of the tip of the intravenous electrode in two. One patient, a diabetic, required two operations to reposition the power generator because of skin ulceration from pressure necrosis. At the last procedure, even though the battery box had

TABLE 1 *Results of Varied Makes and Placements*

Result	Thoraco-Abdominal				Endocardiac	
	Medtronic	Cordis	Total	%	Total	%
Excellent	22	2	24	57	40	75
Good	4	7	11	26	13	25
Poor	7	0	7	17	0	0
Total	33	9	42	100	53	100

broken through the skin over a square centimeter area, it was successfully placed under the muscles of the lateral abdominal wall. All nine patients are now doing well, but they could not be classified as having an excellent result because of the extra procedures required.

Only 17 per cent (7 patients) of the thoraco-abdominal type and none of the endocardial method were classified as having a poor result. This type of result implies that the surgical procedure of pacemaker insertion or the electrical failure of the power generator was the cause of death in the individual. Five patients died in the hospital or within two months after discharge from advanced arteriosclerosis aggravated by thoracotomy. The ages of these patients were from 66 to 90 years. These patients could probably have survived the new technic which makes a thoracotomy unnecessary. The first of the series experienced an infection in the electrical apparatus and required removal of the power generator and wires. He returned to sinus rhythm and died from unknown causes three years after removal of the pacing mechanism. One patient succumbed from a "runaway" pacemaker (pulse 850).

Equipment

As can be seen from Table 1, nine Atricor synchronus pacemakers, produced by the Cordis Company, were used. Thirty-three epicardial electrodes with abdominal power generators, manufactured by the Medtronic Company, have been used. Broken wires and premature power generator failure have plagued both units. The 31 epicardial electrodes with subpectoral power generators are also of Medtronic manufacture. These generally have been of adjustable rate and amplitude. This is desirable because some patients return to a degree of atrioventricular conduction, and the rate of the power generator can then be increased to surpass the patient's own rate. The amount of current required for pacing may have to be increased because of fibrosis around the electrode tip. A straight surgical needle is then used to change either the rate or amplitude percutaneously. The problem of lead breakage similarly is decreasing with the jugular electrode. Although these models have been in use for several years, only one wire breakage has been experienced.

Discussion

Patients can now be freed from Stokes-Adams attacks to resume relatively normal activity, which has been denied them for months or years. Congestive failure has been improved or eliminated, and patients routinely notice a decrease in fatigability. There has been no operative or hospital mortality after installation of a permanent pacemaker since October, 1964. The oldest patient is 94 years old. Renewing of the power generators has not been a problem. Twenty-three procedures have been done, all under local anesthesia, and no infections have been encountered. Currently, Cordis models are replaced at 24 months and Medtronic units at 30 months.

Although the endocardiac electrode is now being used almost routinely, its placement is not without problems. As aforementioned, five patients have required a thoraco-abdominal procedure after unsuccessful jugular implantation. Presently we do not know to what extent these complications are preventable, but with increased experience and improved technic, the incidence of complications, even though minor, is decreasing.

Recently, three "demand" pacemakers, manufactured by the Medtronic Company, have been inserted by way of the jugular electrode system under local anesthesia. The use of this more sophisticated package is indicated in those patients who change from normal sinus rhythm to heart block at irregular intervals. This unit functions only when the patient is in complete heart block or when the heart rate is below 58 beats per minute. In a select group of patients, this electronic equipment would seem to be ideal.

Summary

The advent of the endocardiac electrode has increased the percentage of excellent results to 75 per cent and of good results to 25 per cent. No poor result has been experienced. Notwithstanding the certain percentage of failure, the use of implantable pacemaker in chronic heart block is truly a major advance. Engineering refinements, combined with changing surgical technics, will offer this form of treatment to an increasing number of our aging population.

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Peripheral Vascular Disease

VIII. Thrombophlebitis

RAY W. GIFFORD, JR., M.D.

ETIOLOGIC, prognostic, and therapeutic considerations make worthwhile the following clinical classification of thrombophlebitis:

1. **Superficial thrombophlebitis** rarely gives rise to pulmonary emboli or the late manifestations of chronic venous insufficiency. The most common site of superficial thrombophlebitis is incompetent varicose veins in the lower extremities. It may follow trauma (often minor and sometimes unnoticed) to the varices, or it may occur during pregnancy or after operations. Superficial thrombophlebitis in the upper extremities usually follows intravenous injections of solutions for therapeutic or diagnostic purposes. Spontaneous recurrent superficial thrombophlebitis affecting apparently normal veins may be idiopathic, but it may accompany or be the first clinical manifestation of thromboangiitis obliterans (Buerger's disease), or it may signify an otherwise symptomless malignancy.

The lesions of acute superficial thrombophlebitis are visible and palpable as linear, erythematous, indurated, tender cords along the course of a superficial vein. Treatment consists of rest in bed, with elevation of the affected extremity, and the application of hot, moist packs to it, until the acute inflammatory reaction subsides. Salicylates usually suffice to relieve pain. When the acute inflammatory reaction is unusually severe, phenylbutazone (Butazolidin®), 100 mg. four times daily for 3 or 4 days, usually hastens resolution of the process. Anticoagulants are not necessary unless there is accompanying deep venous thrombosis or unless the thrombus extends proximally. Prolonged use of elastic support is not necessary unless extensive varices are present. Recurrent thrombophlebitis in incompetent saphenous veins is an indication for venous stripping.

2. **Deep thrombophlebitis.** Unlike superficial thrombophlebitis, thrombophlebitis affecting the deep veins poses the threat of pulmonary embolism, and when the femoral, iliac, or axillary veins, or the vena cavae are obstructed, the late sequelae of chronic venous insufficiency are likely to occur. When only deep muscular veins of the calf are affected, edema is not usually present. Diagnosis depends on the finding of tenderness and, sometimes, induration when palpating the calf muscles. Homans' sign is not consistently reliable. Unilateral tenderness is more significant than is bilateral tenderness. When the main venous trunks are obstructed, the entire extremity is swollen, cyanotic, and the superficial veins are prominent and distended. Except in cases of phlegmasia cerulea dolens, arterial pulsations are palpable. In this age of early postoperative ambulation, deep venous thrombosis complicates chronic medical illnesses such as congestive heart failure, carcinomatosis, and ulcerative colitis more frequently than it complicates the postoperative period.

Other causes for deep thrombophlebitis include trauma (not necessarily directly to the affected veins), parturition, occult carcinoma, and, perhaps, therapy with anovulatory drugs. Sometimes deep thrombophlebitis is idiopathic. Treatment consists of bed rest, with elevation of the extremity, application of hot, moist packs, and administration of anticoagulants drugs. In the acute stage, heparin should be administered for several days, followed by therapy with one of the coumarin derivatives for several weeks. Ambulation should be permitted when edema and tenderness have subsided, and, in any event, bed rest should not be enforced for more than 10 to 14 days. Prolonged bed rest fosters the disuse syndrome and postphlebitic neurosis. If edema recurs when the patient becomes ambulatory, a well-fitted elastic support should be worn below the knee until edema does not reappear when the support is removed.

It is important to remember four relevant facts:

More than 50 per cent of pulmonary emboli occur without any peripheral signs or symptoms of thrombophlebitis.

When thrombophlebitis recurs despite adequate anticoagulant therapy, an occult malignancy should be suspected.

Hot packs should not be applied to an extremity with diminished or no arterial pulsations.

There is no entity of "chronic thrombophlebitis." Thrombophlebitis is an acute disease that regresses spontaneously, with resolution or organization of the thrombus within a few weeks. Residual swelling may be present because of damage to valves, which occurred at the time of the acute process and is therefore the result of chronic venous insufficiency.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio.

An Improved Technic for Intracardiac Pacing

ELIAS T. SAADI, M. D.

EXTERNAL percutaneous pacemakers of the flotation type were first reported by Kimball and Killip in 1965.[1] This is a light, limp, unipolar platinum-tipped, Teflon-sheathed, braided steel electrode.* It is floated into the heart through a large bore needle or venatube under electrocardiographic control. Radiography is not necessary. It has the added advantage of bedside application and requires no specialized training other than knowledge of the intracardiac electrocardiagram. In actual practice, however, it has not proved as certain and rapid a method as direct placement under fluoroscopic control. Flotation wires have become popular in coronary patients who cannot be moved readily to a fluoroscopic room. These patients ordinarily are seriously ill and apprehensive. Hence, the importance of the availability of a simple, readily available technic of pacemaker insertion, which can be done quickly and in a low-key atmosphere to allay fears. Unfortunately the flotation technic has been fraught with several disadvantages owing to the uncertainty of its application requiring, not uncommonly, long periods of time at the patients bedside thereby creating apprehension. The purpose of this communication is to present an improved technic for bedside pacing.

Material & Methods

Immediately after the clinical decision to consider the coronary patient as a candidate for endocardial pacing, a special radiopaque intravenous catheter placement unit is inserted into the left antecubital vein.† This intravenous catheter placement unit is inexpensive and disposable. It consists of a 16 gauge, thinwall needle which is inserted into the vein, and a 24 inch, 19 gauge catheter which is inserted through it and passed toward the heart until the superior vena cava or right atrium is reached. The approach from the left arm provides a direct route with a minimum of bends for the catheter. The placement may be checked readily by a portable chest radiograph, or a Polaroid™ film may be used. When a catheter position is deemed to be satisfactory, the inner plastic stylet is removed and the catheter is attached to a slow drip of a 5 per cent dextrose solution. Central venous pressure may now be monitored.

When intracardiac pacing becomes necessary, the catheter hub is disconnected from the dextrose tubing and a special "Y" fitting is attached.‡ This fitting is provided with a rubber disc and chuck for tip occlusion during angiography. In this case, the disc and chuck is replaced by a small gasket and gland. The braided steel electrode is passed through the gasket into the catheter and advanced into the heart using the technic of electrocardiographic monitoring.[1] While the wire is being inserted a constant dextrose drip is maintained through the "Y," preventing blood coagulation. When the wire has been satisfactorily placed in the right ventricle, the gasket is tightened and the gland securely holds the wire. The entire assembly (Fig. 1) is then secured on the forearm. The side opening of the "Y" fitting now may be used for a constant flush, administration of fluids and medication, and measurement of venous pressure. The blow-up view of the special fitting may be seen in Figure 2.

Discussion

The method of intracardiac pacing described here presents an improvement over the standard flotation technic. The radiopaque catheter is easily placed percutaneously into the vein and readily advanced into the right atrium. Its passage requires no special knowledge of cardiac catheterization. In our institution a medical resident passes it on the average of

The Author

● **Dr. Saadi, Youngstown, is Director of Medicine, and Director of Cardiac Laboratory, St. Elizabeth Hospital, Youngstown.**

Submitted January 9, 1968.

*Davis and Geck Division, American Cyanamid Company, Peart River, N. Y.

†Deseret Intracath, Bardic, C. R. Bard, Inc., Murray Hill, N. J.

‡United States Catheter and Instrument Company, Glenn Falls, N. Y.



FIG. 1. *Entire assembly as it appears when placement is complete. The braided wire extends beyond the catheter tip for pacing. The external end of the wire is coiled outside for attachment to the pacemaker.*

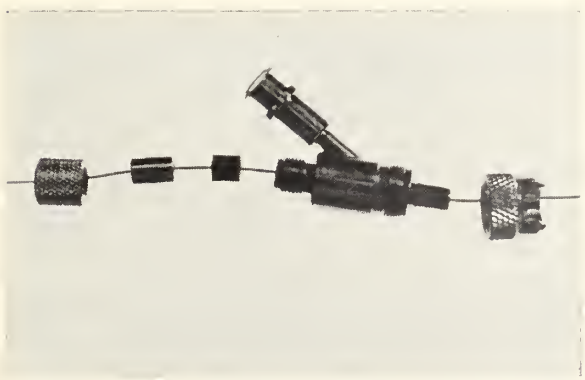


FIG. 2. *Blow-up of special "Y" fitting showing fitting with inner small gasket and gland with wire electrode passing through fitting and into hub of radiopaque catheter. Intravenous solution may be attached to side of fitting.*

two minutes elapsed time. Its simplicity makes it readily applicable to patients as a routine procedure on admission to the coronary care unit.

When a wire is to be inserted, the catheter provides a straight route for its passage, especially since a constant flow of intravenous solution is maintained. The uncertain technic of flotation is practically eliminated, except for the short distance from the catheter tip to the right ventricle, which has presented no problem. The tightly fitting gland holds the wire snugly making it virtually impossible to pull out.

A refinement of the technic is to advance the catheter directly into the right ventricle. The catheter entry into the ventricle is heralded by a rise in pressure on a venous manometer, thereby eliminating any need for radiography or electronic equipment.

The advantage of this improved method is easily appreciated by anyone who has had experience with floating wires. It is direct, painless, requires no cutdown, and is timesaving. Needless to say, it allays patient fears by requiring less time and also provides a route for intravenous administration and venous pressure monitoring.

Results

As of this writing ten patients have had this improved technic applied. In all ten patients the catheter was passed readily into the right atrium. In nine patients the electrode wire was passed successfully into the right ventricle. There was one case of failure to enter the right ventricle for the wire preferred the direct route into the inferior vena cava. In this patient the pacemaker catheter was placed under direct fluoroscopy.

No infections or phlebitis have been seen. The longest duration was six days and the shortest was six hours. No ventricular arrythmias have occurred.

Summary

An improved method of intracardiac pacing is presented. It requires less time than the usual flotation technic and has the added advantage of enabling fluid administration and central venous pressure monitoring.

Acknowledgment: This study has been supported in part by a grant from the Northeastern Ohio Heart Association.

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CHARDACK-GREATBATCH PACEMAKER. — Forty-four patients with chronic complete heart block have been treated by the insertion of the fixed-rate Chardack-Greatbatch endocardial pacemaker.

The preoperative mortality was nil, the postoperative morbidity low.

Of the 53 generators implanted there was one failure (1.9 per cent).

There were six catheter failures (11.3 per cent), all at the beginning of the series, owing to a steel stylet being left inside each catheter.

There have been no catheter or generator failures since May 1966. — W. Forbes, M. B., et al, Glasgow, Scotland: *British Medical Journal,* 2:13-16, April 6, 1968.

Sudden Blindness

Report of a Case Due to Bilateral Optic Neuritis In a Four Year Old Child

FRANK J. WEINSTOCK, M.D.

A FOUR-YEAR-OLD white boy was referred by his pediatrician in April 1967 because of a six hour history of inability to see.

The child was perfectly well until the night before his referral, at which time his mother noticed that he seemed to have some difficulty in finding objects and picking them up. Upon awakening the next morning the child did not seem to have any vision. He was unable to walk because of his blindness, and he complained that he could not see. He accepted this blindness, however, with remarkable calm and did not appear to be alarmed. The past history was completely negative, with no headaches, associated weakness, recent illness, or ingestion of medications.

The physical examination revealed a reliable child, with light perception, who could not distinguish large objects with either eye. The ocular muscles showed a full range of motion with no apparent pain, although there was some reluctance for the child to turn the eyes to the left. The pupils reacted directly and consensually, but the right pupil was sluggish in its reaction.

The only positive findings were obtained from the funduscopic examination, which revealed marked edema of the right optic nerve with multiple hemorrhages surrounding the disc. The macula and periphery of the fundus were normal. In the left eye the margins of the optic nerve were well delineated. There was only a suggestion of pallor of the left disc, but no hemorrhages or exudates were present.

The child was admitted to the hospital and examined by the neurosurgeons. Skull and foramina films, arteriograms, pneumoencephalograms, and radioactive brain scan were all normal. Laboratory data were likewise normal.

In view of all of these findings, the diagnosis of optic neuritis of the right eye and retrobulbar neuritis of the left eye was made.

Two days after admission, the fundus appeared the same and the pupils were equal and reacted to light promptly. At that time the patient could see hand movements with the left eye and could see objects and reach for them. Intramuscular ACTH therapy was instituted for ten days. Seven days after first being seen the child was found to have 20/60 vision in the right eye and 5/200 vision in the left eye. The hemorrhages and edema of the right eye had cleared completely, leaving a sharply defined disc. The left eye remained the same. Three days later the vision was 20/40-2 in the right eye and 20/200 in the left eye. Binocular testing with the Hardy-Rand-Rittler Pseudo-isochromatic Color Vision Test Plates (H-R-R*) showed that the patient missed the first seven plates. Three weeks after the initial examination, the vision improved to 20/40 in the right eye and 20/80 in the left eye.

Four weeks later the vision in each eye was 20/30 and the left eye still appeared to have some temporal pallor of the disc. H-R-R testing showed that the patient still missed some of the first six plates with each eye.

Eight months after first being seen the child's ophthalmologic examination was essentially normal except for his missing six of the first seven H-R-R plates with the left eye.

Discussion

The sudden onset of bilateral blindness in a young child is quite startling and of great concern to the parents, the physician, and the child; although interestingly, the young child may accept this with a re-

The Author

● **Dr. Weinstock, Canton, is Clinical Instructor in Ophthalmology, Ohio State University College of Medicine; a member of the Attending Surgical Staff, Aultman Hospital; Courtesy Staff, Mercy, Timken-Mercy Hospitals and Alliance City Hospital; and Consulting Staffs Molly Stark Hospital and Union Hospital, Dover.**

Submitted January 8, 1968.

* Available from American Optical Company, Buffalo, New York, Catalogue No. 13398.

markable degree of calmness. Older children, as well as adults, may panic in these situations.

Certain causative conditions such as intraocular hemorrhages or retinal detachments can be ruled out very quickly with the use of the ophthalmoscope. Tumors, optic neuritis, and hysteria must of course be evaluated in more detail. In the present case the neurologic and neurosurgical evaluations for intracranial lesions were negative.

Optic neuritis is a condition which, in spite of the relative infrequency in children, must always be considered in cases of sudden bilateral blindness. Many conditions, such as preexisting viral illnesses, multiple sclerosis, congenital syphilis, Leber's disease, malnutrition, diabetes, foci of infection, inflammatory conditions, demyelinating diseases, and many medications, have been implicated as a cause.[1-4]

Although short term results may be very encouraging, probably 20 to 25 years of follow-up would be necessary to be certain of recovery. Multiple sclerosis and demyelinating diseases may not be diagnosed until many years after the acute episode.

More details on this subject can be found in the excellent summary of "Optic Neuritis in Children" by Kennedy and Carroll.[2] In their analysis, they found a greater incidency of bilaterality and papillitis in children than in adults. Twenty-seven per cent of their cases had optic neuritis associated with familial or generalized diseases, 20 per cent associated with multiple sclerosis, and 53 per cent with no cause determined. The cause was felt to be functional (either true conversion hysteria or for secondary gain) in two of their 41 cases. Of 29 children observed by Lowmiller and Knox, no definite cause could be found in 22.[5]

The present case shows evidence of papillitis in one eye which Kennedy and Carroll felt had a poor prognosis. In children the disease is often bilateral as opposed to adults where it is usually unilateral. Vision usually begins to improve in one to four weeks, but occasionally no improvement occurs or permanent blindness results.[6]

The efficacy of therapy in childhood, as in adults, is questionable although ACTH or adrenal steroids are given by many people.

This case also shows the value of the H-R-R test in following optic neuritis.[7] Subtle changes are often noted when other tests are apparently normal. Eight months after the onset, the H-R-R findings are the only residua in this case.

Summary

Optic neuritis in childhood does occur as a bilateral condition which may resolve quite well. It should be emphasized that long term follow-up is essential to rule out causative conditions which do not appear at the time of the original disease, especially multiple sclerosis. The present case is one of the youngest reported and presents the case of a child with isolated bilateral optic neuritis with no other findings, who recovered his vision completely. The child may present to the pediatrician, general practitioner, or the ophthalmologist and all must be acquainted with this entity.

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TRANSIENT BLINDNESS. — Seven patients aged six to 16 years, had transient total blindness following seemingly trivial blunt head trauma. The blindness persisted for a few minutes to three to four hours. With one exception, there were no other ocular abnormalities. Bilateral occipital slowing was noted on the electroencephalogram in the early post-traumatic period. Restlessness and agitation were prominent during the period of blindness, but behavior reverted to normal with the return of vision. Recovery was complete in every case. The type of trauma frequently involving the parieto-occipital regions, the prominence of posterior slowing on the electroencephalogram and the absence of associated ocular abnormalities when the blindness was complete suggest some type of temporary cerebral dysfunction, although the precise mechanism is obscure. — John F. Griffith, M. D., and Philip R. Dodge, M. D., St. Louis, Mo.: *The New England Journal of Medicine,* 278:648-651, March 21, 1968.

Thoracic Aortic Aneurysm In Marfan's Syndrome

A Case Report

EDWIN M. GOYETTE, M.D., JOHN STORER, M.D., and ARCHIBALD L. GRIERSON, M.D.

IN 1896 Antoine Bernard-Jean Marfan[1] described the case of a five and one-half year old girl who had symmetrical malformation of her extremities. She had contractures of the fingers, the elbows and knees with marked retarded development of the locomotor functions without definite nervous disturbance. She also had poor musculature and extreme deficiency of subcutaneous fat. He called this condition *dolichostenomelia* and depicted the fingers and toes as being "spiderlike."

In 1902 Achard[2] described an 18-year-old girl whose deformities were similar to the case that Marfan had presented. He gave this condition the name "arachnodactyly."

There are over 400 cases of the Marfan syndrome mentioned in the literature and the first in the American literature is the case of a 21-month-old child described by Piper and Irvine-Jones[3] in 1926.

The cardinal manifestations of the Marfan syndrome are *skeletal*, *cardiovascular*, and *ocular*. With the skeletal growth there are marked abnormalities such as pectus excavatum, pectus carinatum, dolichocephaly, long narrow face, and high arched palate. The weakness of the ligaments, fascia, tendons and joint capsules is the cause for the manifestations of hernias, hyperextensibility of the joints with habitual dislocations, pes planus, genu recurvatum, and kyphoscoliosis.

The Cardiovascular System

It has been reported[4] that about 30 to 60 per cent of patients with the Marfan syndrome have cardiovascular involvement. The most common complication is cystic medial necrosis of the aorta resulting in dilatation of the aortic root, saccular and dissecting aneurysms of the ascending aorta, redundancy of the aortic cusps, cardiomegaly, and upward displacement of the coronary ostia. It is thought that the dissecting aneurysms are caused by rupture of the vasa vasorum due to weakness of the arterial wall by degeneration of the media with the following formation of an intramural hematoma. These changes come before rupture of the intima.[5] The fact that these ruptures are generally localized to the first centimeters of the aorta may be explained by the greater mechanical strain acting on it. Sudden death is common and is most often due to dissecting aneurysm. It starts with an acute tearing chest pain radiating to the back with variable symptoms depending on the location, size of the aneurysm, and its effect on neighboring structures and blood supply. The attack may be of relatively short duration if there is reentry of the dissection.

The sudden development of a murmur, particularly an early diastolic murmur over the ascending aorta may be a valuable sign pointing to dissection. This murmur is produced by dilatation of the aortic root, resulting in aortic insufficiency. Tolbert and Birchall[6] state that cardiovascular defects are the most common causes of death in Marfan's syndrome and give congestive heart failure and vascular rupture as other causes, in that order.

Ocular Manifestations

Congenital bilateral ectopia lentis is the hallmark of ocular involvement in this syndrome and is found in about 40 per cent of the patients. Weve[7] in 1931 documented ectopia lentis in 33 per cent of 84 cases. The suspensory ligaments visualized by special gonioscopic studies are redundant, attenuated, and at times broken. The lower ligaments are defective and displaced upward. There is excessive length of the eye-

The Authors

- Dr. Goyette, Cleveland, is Chief of Internal Medicine and Director of the Cardiovascular Laboratory of Huron Road Hospital.
- Dr. Storer, Cleveland, is Chief of Thoracic Surgery of Huron Road Hospital.
- Dr. Grierson, Cleveland, is Resident in Internal Medicine at Huron Road Hospital.

Submitted January 11, 1968.



FIG. 1. *Picture of patient taken postoperatively.*

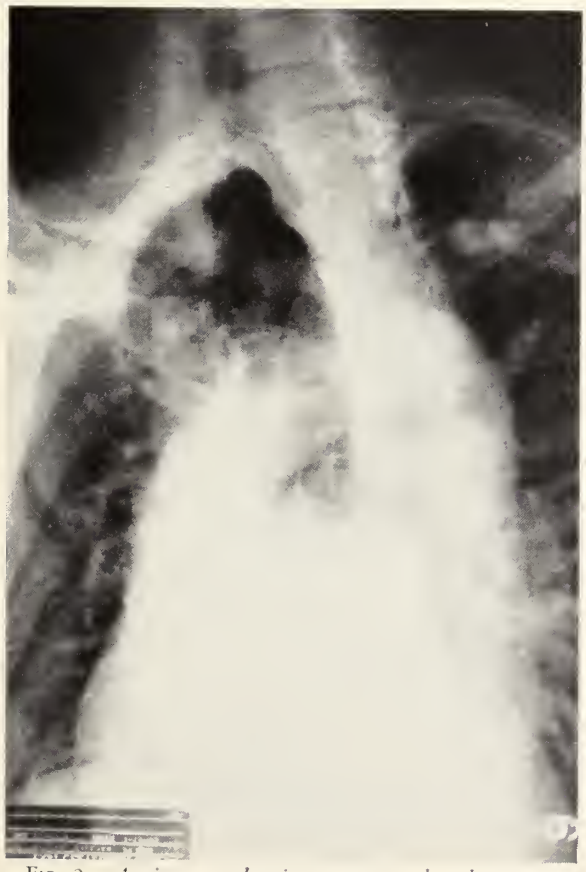


FIG. 2. *Angiogram showing aneurysmal enlargement of the aortic root.*

ball resulting in a high degree of myopia. The defect in the sclera is at times expressed in the cornea as keratoconus or as megalocornea. Abnormal zonular fibers, iris lacking in trabeculae and crypts, uveal pigment deficiencies, and amblyopia are also at times present. Hereditary ectopia lentis alone is not evidence of the Marfan syndrome, since it is also found in the Weil-Marchesani syndrome in short individuals. Myopia may also be present without ectopia lentis, and the pupil is often difficult to dilate. Sautter[8] has found that there is aplasia of the dilatator pupillae.

Case History

The patient is a 34-year-old Negro male who came into the hospital on March 17, 1965 because of hearing a loud noise in his anterior chest with accompanying mild hoarseness, these symptoms having appeared approximately one week prior to admission. The patient claimed to have been in good health all his life except for correction of bilateral dislocated lenses a few years previously and a repair of a left inguinal hernia six months before. He worked for the post office and lived a normal life.

Family History

The patient's grandfather and his uncle had Marfan's syndrome. He had three children: the 6-year-old son was normal, but the 8-year-old son and 11-year-old daughter showed typical Marfan features.

Physical Examination

This revealed a tall, slender, Negro male in no acute distress. His height, span, heel-to-pubis, and vertex measurements were 72, 78, 38½ and 33½ inches respectively; weight was 184 pounds. The blood pressure was 130/50 and equal in both arms; the pulse rate was 96 per minute, Corrigan in type; and respiration rate was 24 per minute. He had arachnodactyly, high arched palate, hammer toes, and he wore thick glasses. There was a Grade VI diastolic murmur, which could be heard without the aid of a stethoscope, loudest along the right sternal border but audible all over the precordium. His abdomen was soft and a left inguinal hernia scar was present. Peripheral pulses were equal and normal.

Laboratory Reports

The hemogram was normal except for the erythrocyte sedimentation rate (ESR) of 103 mm. hr., urinalysis was unremarkable, and Pangborn test was negative. An electrocardiogram revealed normal sinus rhythm, a rate of 79, and a right bundle branch block. The circulation time was 21 seconds. An angiogram revealed aneurysmal enlargement of the root of the aorta with dilatation of the remaining portion.

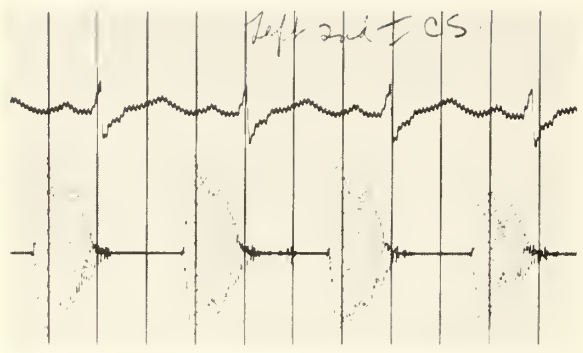


FIG. 3. *Phonocardiogram taken before surgery showing diastolic murmur.*

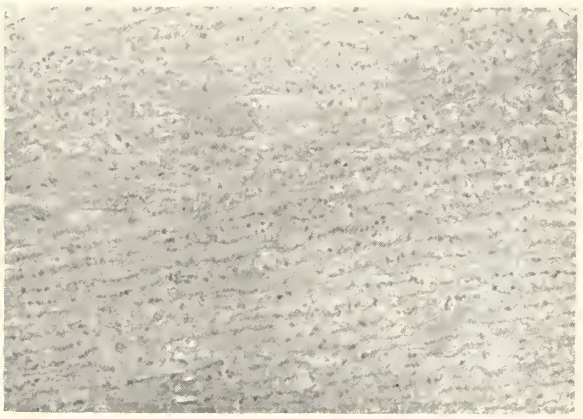


FIG. 4. *Microscopic view of a normal ascending aorta (H. and E.)*



FIG. 5. *Microscopic view of specimen from the patient showing cystic medial necrosis (H. and E.).*

Hospital Course

Two weeks after admission the patient was operated on through a sternal-splitting incision with total cardiopulmonary bypass. At the time of the operation an aneurysm of the sinus Valsalva was found with dilatation of the root of the aorta producing aortic insufficiency.

The operation performed was bicuspidization of the aortic valve by removal of the noncoronary cusp and insertion of a Teflon graft in the ascending aorta.[9] The patient tolerated the procedure well. Two weeks after surgery he reported no particular compliants. His blood pressure was 142/86, temperature 37.7C, pulse rate 96 per minute, respiratory rate 20 per minute, and the electrocardiogram showed sinus tachycardia of 115 and right bundle branch block. A Grade I diastolic murmur could be heard along the left sternal border.

The microscopic specimen from the operation showed mucoid degeneration of the aorta (cystic medial necrosis).

The patient's three children came to the hospital and were examined. A male child of six years was normal. Another male child, age eight years, had had two operations on his eyes for dislocated lens, had pectus carinatum, high arched palate, and typical features of Marfan's syndrome but normal heart sounds, and normal electrocardiogram and chest x-ray findings. The third child, an eleven-year-old girl, also had typical Marfan features, had had four operations on her eyes for dislocated lens, but had normal heart sounds, a normal electrocardiogram, and normal chest radiographs.

The patient returned to the hospital in March 1967 (two years after his operation) for a check-up and reported that he had been back working at the post office for almost two years and had not missed a day of work due to illness.

On physical examination his blood pressure was 140/80, temperature 37.2C, pulse rate 92 per minute, respiratory rate 20 per minute, and the electrocardiogram showed a right bundle branch block. A grade I diastolic murmur could still be heard along the left sternal border.

Discussion

McKusick[10] believes that the inheritance pattern of this syndrome is determined by a simple Mendelian autosomal dominant. The basic connective tissue abnormality is not definitely known but is pathologically similar to that described in 1929 by Erdheim[11] in his paper entitled "Medionecrosis aortae idiopathica."

The Marfan syndrome is quite varied in regard to skeletal, cardiovascular, and ocular manifestations.

The skeletal features are generally striking and it is usually through these discoveries, i.e., "arachnodactyly," that individuals are first studied.



FIG. 6. *Patient's two sons.*



FIG. 7. *Patient's daughter.*

The cardiovascular lesions are the most varied and some may be found only at the time of autopsy. Some patients have fusiform or saccular aneurysm or a dilated ring, while others have dissecting aneurysms. Some of the dissecting aneurysms have caused sudden death. Another explanation of unexpected death is cardiac arrhythmia due to pathologic changes in the sinus and atrioventricular nodes and those involving the nodal vessels.[12]

In this case, there was evidence of aortic regurgitation and the chest films showed a relatively normal heart, but the angiogram was invaluable in revealing the aneurysm. There have been reports of coarctation of the aorta, and aneurysms of this vessel and others such as the carotid, subclavian, pulmonary, splenic, renal, and femoral arteries.[13,14] Less common are interventricular septal defect, patent ductus arteriosus, and congenital absence of the pulmonary valve.[6,15]

It is advisable for these people to be seen by an eye specialist so that he can help them to improve their vision, since ectopia lentis is the chief ocular disorder.

Preliminary reports of increased hydroxyproline urinary excretion in this syndrome have been issued.[16,17] In the future this test may become of great value in screening the forme fruste variants. Hydroxyproline is present in the body almost entirely in collagen.

The purpose of this paper is to reaffirm the varied abnormalities presented in this heritable disease and to further emphasize the fact that it is necessary to diagnose the cases early, to follow them carefully, and to be ready for any of the many possible complications.

Summary

The case of a 34-year-old male with Marfan's syndrome and with thoracic aortic aneurysm was presented. Bicuspidization of the aortic valve was performed and a Teflon graft inserted in the ascending aorta. The aortic wall revealed cystic medial necrosis. The patient's grandfather, uncle, and two of his children had conspicuous findings of the Marfan syndrome. The skeletal, cardiovascular and ocular manifestations were discussed.

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GENETIC COUNSELING should be considered an integral part of the medical management of the patient with hereditary disease. This is even more important when dealing with life threatening diseases such as cancer. Physicians certainly are aware of the importance of genetic counseling but all too often have referred these problems to nonmedically trained geneticists. McKusick has taken issue with this attitude; he believes that genetic counseling should be done more frequently by the physician who is closest to the patient's problem. He observed:

"Too long genetic counseling has, by default, fallen to the province of the college professor of genetics, who is informed that the diagnosis is Humpty Dumpty's disease, who looks up the usual mode of inheritance of H-D disease in a book and on the basis of this and the specific pedigree gives advice. Genetic counseling, like other medical prognoses, should be an integral part of the practice of clinical medicine. The physician is in the best position to meet (the patient's needs for genetic counseling) . . . (and) with improved education in medical genetics sound genetic counseling should become the rule in medical practice."

We subscribe wholeheartedly to this philosophy and think that the entire management of the complex cancer problem, including genetic counseling, should be under the physician's direction. — Henry T. Lynch, M. D., and Anne J. Krush, M. S., Omaha: *Southern Medical Journal*, 61:265-269, March 1968.

Electrocardiographic-Pathologic Conference

Emphysema and Cor Pulmonale

RALPH C. SCOTT, M.D.*

THE FORMAT of the electrocardiographic-pathologic conference (EPC) has been outlined in the first article in the series.[1]

Electrocardiographic Interpretation (Fig. 1)

The electrocardiogram shows low voltage in the limb leads. There are S waves in all precordial leads. The T waves are diphasic (−+) in the mid and left precordial leads. Atrial fibrillation is present.

The tracing is highly suggestive of pulmonary emphysema. Attention is directed to the extremely low voltage of all complexes in lead I and also in lead aVL. The S waves are quite shallow in V_1. The prominent positive deflection in the mid and left precordial leads may be a large U wave, merging with the terminal portion of the T wave, and would raise the possibility of hypokalemia.

This electrocardiogram was recorded on December 16, 1966. Tracings recorded in February 1966 showed an S_1, S_2, S_3 pattern. Later tracings, including the one illustrated, no longer clearly displayed this S_1, S_2, S_3 pattern. The mean QRS axis is approximately +90° and the mean P wave axis is also +90°. The very shallow S waves in V_1 would raise the additional possibility of right ventricular hypertrophy.

Electrocardiographic Summary:

(1) Consistent with pulmonary emphysema
(2) Possible right ventricular hypertrophy
(3) Atrial fibrillation
(4) Digitalis effect
(5) Possible hypokalemia

Clinical Resume

This 53 year old white man was first seen in the Out-Patient Department of the Cincinnati General Hospital in February 1966 because of long-standing asthma and signs of congestive heart failure. Symptoms of heart failure first appeared in 1961, and he had received sporadic treatment elsewhere with relief of symptoms. In addition to his cardiopulmonary problems he also gave a history of excessive alcohol ingestion. The latter problem led to his hospitalization at the Cincinnati General Hospital on December 10, 1966 with impending delirium tremens. In the hospital he was found to have pulmonary insufficiency, hypoxia, and polycythemia. He had atrial fibrillation with a fast ventricular rate. He was treated with digitalis, diuretics, intermittent positive pressure breathing, and antibiotics. On his fourth hospital day he became stuporous and although he appeared to show some improvement on the sixth hospital day, he died on December 17, 1966.

A chest x-ray was reported as showing emphysematous changes plus lower lobe infiltrates.

Necropsy Findings

The heart weighed 640 Gm. in the fresh state and 377 Gm. after epicardial dissection. The right ventricle measured 5 mm. in thickness and the left ventricle, 18 mm. in thickness. The weight of the left ventricular free wall plus the interventricular septum was 163 Gm. and the weight of the right ventricular free wall was 79 Gm. The ratio of the left ventricle plus septum to the right ventricle was 2.05. This is consistent with pure right ventricular hypertrophy. The coronary arteries exhibited diffuse atherosclerosis with focal calcification but no significant narrowing of the branches. There was a large amount of epicardial fat, amounting to 30 per cent of the original heart weight. There was moderately severe right atrial dilatation and mild left atrial dilatation but no significant dilatation of the ventricular chambers. There was marked fatty infiltration into the interatrial septum and the atria giving falsely high weights (right atrium, 49 Gm.; left atrium, 41 Gm.; interatrial septum, 27 Gm.).

There was moderately severe centrolobular pulmonary emphysema with marked pulmonary artery sclerosis and dilatation and, marked bilateral lobular pneumonia.

Anatomic Diagnoses:

(1) Cor pulmonale with:
    (a) Right ventricular hypertrophy, marked
    (b) Right atrial hypertrophy and dilatation

From the Cardiac Laboratory, Cincinnati General Hospital and the Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. Submitted April 19, 1968.

*Dr. Scott, Cincinnati, is Associate Professor of Medicine, University of Cincinnati College of Medicine, and Director of Cardiac Clinics, Cincinnati General Hospital.

(2) Lipomatosis of heart

(3) Centrolobular pulmonary emphysema

(4) Pulmonary artery sclerosis and dilatation, marked

Comments

This case illustrates the electrocardiographic findings that may be encountered in pulmonary emphysema complicated by cor pulmonale. It has been repeatedly emphasized that the electrocardiogram in emphysema alone may be very difficult to differentiate from that occurring in emphysema plus cor pulmonale.[2,3] Such findings as abnormal right axis deviation, low voltage in the limb and left precordial leads, prominent S waves in all precordial leads, and tall peaked P waves in the inferior leads may all be encountered in pulmonary emphysema alone. It has been found, however, that the occurrence of abnormal right axis deviation of +110 or greater and or the occurrence of a classic right ventricular hypertrophy pattern in the right precordial leads consisting of a QR pattern or an RS ratio less than one suggests the additional diagnosis of complicating right ventricular hypertrophy.

This electrocardiogram displays no features that are truly diagnostic of right ventricular hypertrophy. It was suggsted, however, because of the very shallow S waves in V_1. At autopsy the findings were those of moderately severe centrolobular pulmonary emphysema complicated by marked right ventricular hypertrophy and right atrial hypertrophy and dilatation. It was not possible to predict the right atrial enlargement from the electrocardiogram in the presence of atrial fibrillation.

Acknowledgments: The author wishes to express his thanks to Dr. William Sueoka who performed the detailed necropsy examination in this case, and to Dr. Robert J. Norris and Dr. Emmett Conyers for their participation in the electrocardiographic and clinical correlation.

Supported in part by Public Health Service Research Grant No. HE-08578. Additional support was received from the Heart Association of Southwestern Ohio, Inc.

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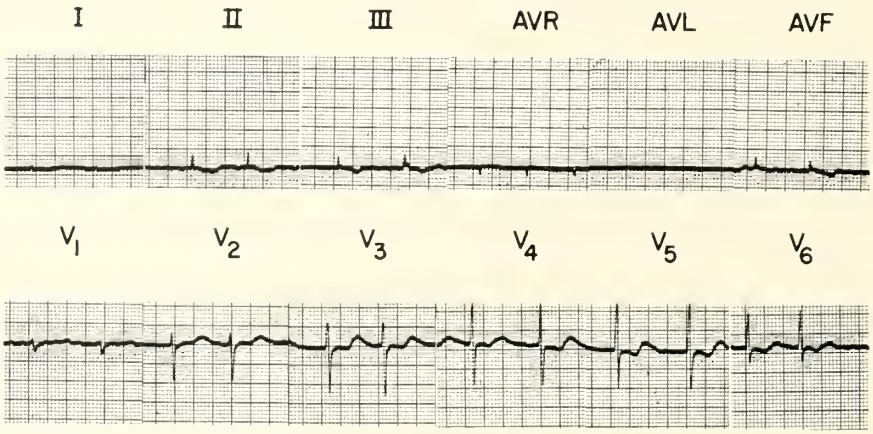


FIG. 1. *The electrocardiogram recorded on December 16, 1966 displays low voltage in the limb leads. This is particularly striking in lead I and in aVL. There are S waves in all of the precordial leads. Atrial fibrillation is present. The T waves are diphasic in the mid and left precordial leads. The terminal positive deflection may be a large U wave raising the possibility of hypokalemia. The configuration of this tracing is highly suggestive of pulmonary emphysema. The mean QRS axis is +90°. The very shallow S waves in V_1 raise the additional possibility of associated right ventricular hypertrophy.*

GP Scientific Assembly . . .

Annual Program Scheduled in Dayton, July 30-August 1; All Physicians, Medical Students Invited to Be Present

THE 18th Annual Scientific Assembly of the Ohio Academy of General Practice will be held at the Sheraton-Dayton Hotel, Dayton, Tuesday, Wednesday, and Thursday, July 30, 31, and August 1. An invitation has been issued for attendance by physicians in all branches of practice, residents, interns, and medical students.

The program is acceptable for 12 prescribed AAGP accredited hours. Persons interested in attending breakfast and luncheon sessions should contact the OAGP office at 4075 N. High Street in Columbus.

Registration opens at noon on Tuesday, July 30. The program has been announced as follows:

Tuesday Afternoon, July 30

Management of the Alcoholic by the Family Physician — Edwin Dunlap, M. D., Attleboro, Mass.

Clinical Difference Between the Two Halves of the Colon — Manuel E. Lichtenstein, M. D., Chicago.

Office Management of Anorectal Lesions — Raymond J. Jackman, M. D., Rochester, Minn.

Future of Medicine — Panel

- Moderator — Carroll L. Witten, M. D., Louisville, Ky.
- **Organized Medicine** — Dr. Witten.
- **Legislative Viewpoint** — Jerrold M. Michael, Silversprings, Ky.
- **Labor's Viewpoint** — Nelson Cruikshank, Washington, D. C.

Wednesday Morning, July 31

"Cornflakes" Conference

- **What It Means to Be a Human Being** — G. Herbert True, Ph. D.
- **Parables in Medical Education** — Dr. Lichtenstein
- **Advantages of Ligation Treatment of Hemorrhoids over Injection Therapy** — Dr. Jackman
- **Eye Conditions and Therapy for GPs** — Robert W. Saul, M. D., Pittsburgh
- **Principles of Diabetic Management** — Joseph H. Skom, M. D., Chicago
- **Symposium on the Vineberg** — Panel — Frank J. Gregg, M. D., William B. Ford, M. D., and Samuel R. Bauersfeld, M. D., Pittsburgh

Wednesday Luncheon Session

"Sandwich" Seminars

- **Soothing Anxieties** — Dr. True
- **Learning Difficulties** — W. B. Taggart, M. D.
- **Selection of Patient for Vineberg Operation and Postoperative Care** — Dr. Gregg
- **Equal Care for Infants** — H. William Clatworthy, Jr., M. D.
- **Detection and Management of Eye Conditions** — Dr. Saul

Wednesday Afternoon

Childhood Appendicitis — Dr. Clatworthy

Hemolytic Streptococcus and Its Relationship to Rheumatic Fever — Dr. Taggart

Good 'Nuf Is Not 'Nuf for the Family Doctor — Dr. True

Wednesday Evening — Marion Laboratory Party and Officers Reception

Thursday Morning, Aug. 1

Exhibitors' Breakfast

Successful Treatment in the Difficult Case of Vaginal Discharge — H. Close Hesseltine, M. D., Chicago

Female Frigidity — Zelique Katz, M. D., Dayton

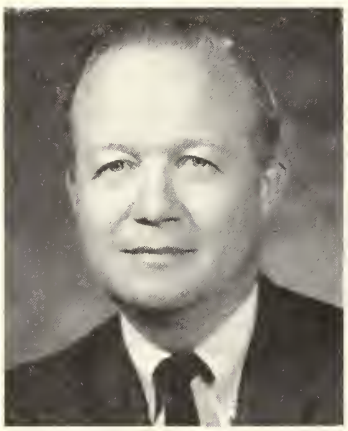
Morals, Marriage, and Medicine — Beverley T. Mead, M. D., Omaha, Nebraska

Presenting Officers and Councilors Elected at the Annual Meeting

THE HOUSE OF DELEGATES of the Ohio State Medical Association named a President-Elect and two new Councilors at the 1968 Annual Meeting in Cincinnati, May 13-17. House action also included election of one Councilor previously appointed by The Council, and re-election of certain other members of The Council. Following are brief biographical sketches of the new officers and Councilors, with additional information on other members of The Council.

Dr. Robert N. Smith, of Toledo, was named President-Elect of the Association and will assume the Presidency at the 1969 Annual Meeting in Columbus. A native of northwestern Ohio, he returned to the area for his internship at Toledo Hospital, and subsequently opened his practice in Toledo where he is now specializing in anesthesiology in association with a group of specialists in that field. He has served since 1963 as Councilor of the Fourth District.

Dr. Smith was born in Swanton, Fulton County, and received his early education there. He began his college training at the University of Michigan, then received an appointment to the U. S. Military Academy at West Point, entering there with the Class of 1943. After graduating with a B. S. degree, he entered military service during World War II as an Air Force pilot; was later assigned to the Wright-Patterson Air Force Base as a research project officer, and from there went to the Massachusetts Institute of Technology where he received an M. S. degree.



Dr. Smith

Following his tour of military service, he entered the University of Nebraska College of Medicine with the Class of 1952. After his internship and a brief period of general practice, he began specialized training. He is a Fellow of the American College of Anesthesiology and a Diplomate of the American Board of Anesthesiology. Professional affiliations also include membership in the Toledo Anesthesia Society, the Ohio and the American Societies of Anesthesiology.

In local medical organization work, he has been active on a number of Toledo Academy committees; was medical director of the local polio oral vaccine immunization program, one of the early and highly successful campaigns in the country. He was also chairman of the Disaster Medical Care program, and was formerly Treasurer of the Academy. Local hospitals with which he is associated include Toledo, Mercy, and Riverside.

On the State level, he has served on the OSMA Committee on Auditing and Appropriations, Committee on Legislation, Committee on Redistricting, the Advisory Committee to the Ohio State Society of Medical Assistants, and he was chairman of the Nominating Committee for the Board of Ohio Medical Indemnity.

He is a member of the American Medical Association and is now serving as Alternate Delegate of OSMA to the AMA House of Delegates.

Community organization activities include membership on the Board of Hearing and Speech Center; appointment as advisor from the Toledo Academy to the American Red Cross; membership in the Parent-Teacher Association; and membership on the Chamber of Commerce, the Rotary Club, and several Masonic orders including the Scottish Rite. He is also a member of Nu Sigma Nu, Chi Phi, Sigma Xi, and Alpha Omega Alpha.

Dr. Smith is married to the former Marilyn Jane Collins, of Columbus. Children are Sandralyn and Sharen, both married; and at home, Robert, Jr., Marilyn Ann, Marcia Jeanne, and Elizabeth. The family church is St. Michael's in the Hills. Two brothers are both physicians.

Incoming President

Dr. Theodore L. Light, Dayton, was installed as President of the Association at the final session of the House of Delegates on May 16, and assumed office at the close of the 1968 Annual Meeting in Cincinnati. He was named President-Elect at the 1967 Annual Meeting in Columbus, after serving four years on The Council as Councilor of the Second District.



Dr. Light

Dr. Light is a native of Dayton. His undergraduate training was at the University of Cincinnati where he remained to receive his medical degree from the University of Cincinnati College of Medicine in 1937. Internship and residency training followed at Miami Valley Hospital.

During World War II, Dr. Light became a flight surgeon with the 319th Bomber Group, and served in the Mediterranean Theater. Active service was from 1942 to 1945. His membership in the Montgomery County Medical Society, and in the State Association, dates back to 1938, and he was a member of the Council of the local Society from 1947 to 1957; was secretary, 1947; vice-president, 1948 and 1951; and president, 1955. In 1956 he received the Outstanding Service Award of the Society. From 1950 to 1963 he was a delegate of the local Society to the OSMA House of Delegates.

Dr. Light was elected to The Council of the Ohio State Medical Association in 1963 as Councilor of the Second District, and was re-elected to that office in 1965. In 1959 he was first elected an Alternate Delegate to the American Medical Association, and 1964 was elected a full Delegate.

In addition to his memberships in the local and state associations as well as the AMA, he is a member of the Aero Space Medical Association, Civil Aviation Medical Association, and Industrial Medical Association. Other affiliations include memberships on the Dayton Area Heart Association Executive Board, Hospital Planning Council of the Greater Miami Valley Medical Advisory Committee, Kettering Memorial Hospital Foundation, in which he is cochairman of the Medical Advisory Committee, and chairman of the Building Plans Committee, and Montgomery County Society for Cancer Control Executive Board. Since February of 1966 he has been on the Governor's Advisory Committee for Title XIX of the Ohio Department of Public Welfare.

Dr. and Mrs. Light have four children — Richard who is a doctor of medicine, Linda and Eleanor, registered nurses, and Mary Ellen, a student.

Third District Councilor

The House of Delegates elected Dr. Dwight L. Becker, Lima, as Councilor of the Third District to succeed Dr. Frederick T. Merchant, of Marion, who was not a candidate for re-election.

A practicing physician in Lima, Dr. Becker has been an active participant in medical organization work. He has served in numerous capacities with the Academy of Medicine of Lima and Allen County and was its president in 1963. Previously, in 1958, he was president of the Lima and Allen County Academy of General Practice. He has been a delegate from the local Academy to the OSMA House of Delegates since 1956.



Dr. Becker

Dr. Becker has served on the Board of Directors of Ohio Medical Indemnity since 1960 and in 1964 was its treasurer. Among state level committees he has served on is the OSMA Com-

mittee on Governmental Medical Care Programs; chairman of the Subcommittee on Comprehensive Areawide Health Care Planning, and representative of OSMA on the Advisory Council on Areawide Health Care Planning.

Dr. Becker is a native of Mercer County and graduated from Spencerville High School. He attended Ohio State University and received his medical degree from the OSU College of Medicine in 1943. Internship was at Christ Hospital in Cincinnati, after which he went into service with the Army Medical Corps and remained on active duty for the duration of World War II.

He entered the general practice of Medicine in Leipsic in July, 1946 and in early 1949 moved to Lima. Among professional activities he was chief of staff of Lima Memorial Hospital in 1959. At present, Dr. Becker is associated with a four-man group to provide service for emergency room service at Lima Memorial Hospital, plus providing medical care for Excello, Standard Oil Refinery, and Proctor and Gamble Distributing Company, in Lima.

Among community activities, he has served as director of the Lima Chamber of Commerce and a director of the Lima YMCA. At present he is an elder in the First United Church of Christ, and a member of Phi Beta Kappa fraternity. He is married to the former Mary K. Lauer and has three children — a son who is now a junior in medicine at Ohio State, a daughter recently graduated in nursing at Ohio State, and a second son majoring in mathematics and physics at Ohio State.

Fourth District Councilor

The House of Delegates elected Dr. George N. Bates, of Toledo, to complete the unexpired term of Dr. Robert N. Smith, who was named President-Elect. Dr. Bates is a practicing surgeon in Toledo, a former secretary of the Academy of Medicine of Toledo and Lucas County, and a delegate of the Toledo Academy to the Ohio State Medical Association.

Dr. Bates was born in Morrisville, Vermont, and received much of his early education in that New England community. For his undergraduate college training he enrolled at the University of Notre Dame and was awarded a B. S. degree in 1937. Medical education followed at McGill University, Montreal, Quebec, Canada, where the Faculty of Medicine bestowed upon him the M. D., C. M. degree in 1942.

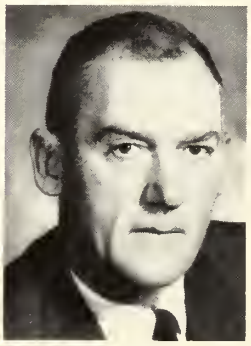
He remained in Montreal for his internship and some residency training in surgery at St. Mary's Hospital, then continued residency training in surgery at St. Vincent's Hospital in Toledo. Now a Fellow of the American College of Surgeons, a Fellow of the International College of Surgeons, and a diplomate of the American Board of Surgery, he and his associate, Dr. Frank E. Foss have offices at 316 Michigan Street, Toledo. He is a member of the American Medical Association and is medical director in the U. S. Public Health Service Reserve.


Dr. Bates

Dr. Bates is married to the former Louise LeSage and has six children. The family home is at 2102 Shenandoah Road.

Eighth District Councilor

Dr. William M. Wells, of Newark, was elected by the House of Delegates to fill the remaining year of an unexpired term as Councilor of the Eighth District. The Council in September, 1967, appointed Dr. Wells to complete the first year of the unexpired term when Dr. James A. Quinn, also of Newark, resigned from that position because he was leaving the state.


Dr. Wells

A general practitioner in Newark, Dr. Wells has been in the Licking County seat since 1949. He is on the senior staff of Licking County Memorial Hospital, at present is chief of staff, and for six years has been a member of the Board of Trustees of the hospital.

An active participant in medical organization work, Dr. Wells is a past president of the Licking County Medical Society, and on the state level has served on the OSMA Committee on Care of the Aging and on the Committee on Government Medical Care Programs. He also has served on the Committee on Industrial Medicine.

He is a member of the Board of Directors and the Executive Committee of the Ohio Citizens Council for Health and Welfare.

Dr. Wells is a native of Columbus, and received his undergraduate training at Ohio State University, where he remained to receive his medical degree from the OSU College of Medicine in 1942. Internship was at University Hospital in Columbus.

After three years of active service in the Army Medical Corps during World War II, he returned to University Hospital for a year of residency training in surgery.

Dr. Wells is married and has three sons and a daughter.

Other Members of The Council

Dr. Robert E. Howard, Cincinnati, will serve an additional year on The Council as Immediate Past President.

Dr. James L. Henry, of Grove City and Columbus, is beginning his second year of a three-year term as Treasurer.

Dr. Paul N. Ivins, Hamilton, was re-elected Councilor of the First District. He was first elected to that office in 1966.

Dr. P. John Robechek, Cleveland, was re-elected Councilor of the Fifth District. He was first elected to that office in 1964 and re-elected in 1966.

Dr. Sanford Press, Steubenville, was re-elected Councilor of the Seventh District. He was first elected to that office in 1966.

Dr. Oscar W. Clarke, Gallipolis, was re-elected Councilor of the Ninth District. He was appointed to that office by The Council in September, 1966, to fill part of the first year of an unexpired term, and was elected by the House of Delegates in 1967 to complete the remaining year of the unexpired term.

Dr. William R. Schultz, Wooster, was re-elected Councilor of the Eleventh District. He was first elected to that office in 1965 to fill one year of an unexpired term, and was re-elected in 1966.

Councilors in the midst of two-year terms are Dr. George J. Schroer, Sidney, Second District; Dr. Edwin R. Westbrook, Warren, Sixth District; and Dr. Richard L. Fulton, Columbus, Tenth District.

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Proceedings of the House of Delegates 1968 Annual Meeting

MINUTES OF FIRST SESSION

THE FIRST SESSION of the House of Delegates of the Ohio State Medical Association was held in the Hall of Mirrors, Netherland Hilton Hotel, Cincinnati, Monday, May 13, 1968. A buffet dinner was held in the Pavillon Caprice preceding the business session.

The Reverend Roger B. Rollins, St. Andrew's Episcopal Church, Dayton, offered the invocation.

Following the invocation, Dr. Stanley D. Simon, Cincinnati, President of the Academy of Medicine of Cincinnati, welcomed the delegates to Cincinnati and introduced President Robert E. Howard, Cincinnati, who delivered his presidential address. (See pages 848-849 for Dr. Howard's address.)

Report on Delegates Present

Dr. Chester J. Brian, Preble County, chairman of the Credentials Committee, reported 151 delegates seated and eligible to vote. A number of alternate delegates, and executive secretaries of county medical societies were in attendance.

1967 Minutes Approved

The minutes of the 1967 sessions of the House of Delegates, as published in the July, 1967, issue of *The Ohio State Medical Journal,* were approved by official action.

Introduction of Guests

Dr. Howard introduced the following honored guests:

Dr. Bradley M. Harris, Ypsilanti, Michigan, President of the Michigan State Medical Society, and Dr. Richard V. Lynch, Jr., Clarksburg, West Virginia, President of the West Virginia State Medical Association, who addressed the House; Dr. B. L. Huffman, Toledo, President, Ohio Academy of General Practice; Dr. Lloyd E. Larrick, Cincinnati, President, Ohio Hospital Association; Dr. John R. Wilson, Columbus, President, Ohio Dental Association; Dr. William J. Roenigk, Cincinnati, Vice-President, Ohio Veterinary Medical Association; Dr. Max A. Myers, Troy, Treasurer, Ohio State Pharmaceutical Association; Mrs. J. Paul Sauvageot, Akron, President, Woman's Auxiliary to the Ohio State Medical Association, and Dr. Sauvageot; Mrs. Malachi W. Sloan, II, Dayton, President-Elect, Woman's Auxiliary to the Ohio State Medical Association; Mrs. Harry L. Fry, Cincinnati, convention chairman for the Auxiliary, and Dr. Fry.

OSMA Past Presidents Introduced

The following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. Robert S. Martin, Zanesville; Dr. Richard L. Meiling, Columbus; Dr. Lawrence C. Meredith, Elyria; Dr. Horatio T. Pease, Wadsworth; Dr. George W. Petznick, Cleveland; Dr. Robert E. Tschantz, Canton; Dr. George A. Woodhouse, Miami, Florida; and Dr. Frank H. Mayfield, Cincinnati.

Also introduced were former members of The Council: Dr. Fred P. Berlin, Lima; Dr. Robert C. Beardsley, Zanesville; Dr. Philip B. Hardymon, Columbus; Dr. J. P. McAfee, Portsmouth; Dr. Edwin R. Murbach, Archbold; Dr. Paul F. Orr, Perrysburg; Dr. Chester P. Swett, Lancaster.

Dr. Samuel Saslaw Commended

The President commended Dr. Samuel Saslaw, Columbus, Chairman of the Committee on Scientific Work for the past five years, and thanked him on behalf of the House of Delegates for his diligent leadership with regard to the scientific and educational program of the Ohio State Medical Association as exemplified in the annual meeting.

Report of Woman's Auxiliary President

Mrs. J. Paul Sauvageot, Akron, President of the Woman's Auxiliary to the Ohio State Medical Association, was presented and gave a report on Auxiliary activities during her administration as president. (See pages 860-861 for the text of Mrs. Sauvageot's address.)

AMA-ERF Checks Presented

The following representatives of Ohio's medical schools were presented checks from the American Medical Association Medical Education and Research Foundation by Dr. Robert S. Martin, Zanesville, chairman of the Ohio Committee for the American Medical Association's Education and Research Foun-

dation: Dr. Clifford G. Grulee, Jr., Dean, University of Cincinnati College of Medicine; Dr. Richard L. Meiling, Dean, Ohio State University College of Medicine; Dr. David Fishman, representing the Case Western Reserve University School of Medicine; Dr. Frank F. A. Rawling, representing the Medical College of Ohio at Toledo.

AMA Certificates of Humanitarian Service

Certificates of humanitarian service were awarded to five Ohio physicians for their service in South Vietnam by the American Medical Association. Present to receive their certificates were the following Ohio physicians: Dr. Robert C. Cahill, Attica and Dr. John E. Stephens, Columbus. The certificate for Dr. Robert G. Smith, Circleville, was accepted in his behalf by Dr. Jasper Hedges, Circleville, since Dr. Smith was on his second tour of duty in Vietnam and was unable to be present. Dr. Clinton W. Trott, Mt. Vernon, was unable to be present because of emergency relief work in Bengasi, Libya. Dr. Lois Zimmerman, St. Clairsville, was unable to be present.

Council Plaques Presented

Plaques for service on the OSMA Council were presented to Dr. Lawrence C. Meredith, Elyria, and Dr. Frederick T. Merchant, Marion. Dr. James A. Quinn, Jr., formerly of Newark, was unable to be present to receive his award.

OSMA Receives Carving of Insignia

Dr. Lawrence C. Meredith, Elyria, Past President of the Association, presented to the House of Delegates a 36 inch replica of the Ohio State Medical Association seal which he carved of wood, a work of 92 hours duration. The insignia will face the entrance way to the OSMA headquarters office.

Reference Committees Appointed

The following House of Delegates Reference Committees were appointed by the President:

Credentials of Delegates — Chester J. Brian, Preble County, Chairman; Paul A. Mielcarek, Cuyahoga County; G. E. DeCicco, Mahoning County; Myrle D. Shilling, Ashland.

President's Address — Jack Schreiber, Mahoning County, Chairman; Robert A. Bruce, Montgomery County; Charles A. Browning, Logan County; Cyrus R. Wood, Ottawa County; H. William Porterfield, Franklin County.

Resolutions Committee No. 1 — James C. McLarnan, Knox County, Chairman; Carl A. Minning, Clermont County; Jerry L. Hammon, Miami County; Dwight L. Becker, Allen County; Robert A. Borden, Sandusky County; William V. Trowbridge, Cuyahoga County; Thomas W. Jackson, Summit County; Robert E. Rinderknecht, Tuscarawas County; Chester P. Swett, Fairfield County; A. M. Shrader, Pike County; William R. Graham, Huron County.

Resolutions Committee No. 2 — Frederick P. Osgood, Lucas County, Chairman; Daniel V. Jones, Hamilton County; James G. Tye, Montgomery County; H. C. Smith, Van Wert County; Robert A. Irvin, Lake County; Maurice F. Lieber, Stark County; Robert R. Johnson, Coshocton County; Kenneth E. Bennett, Washington County; A. Justin Payne, Lawrence County; Jasper M. Hedges, Pickaway County; Albert B. Huff, Wayne County.

Resolutions Committee No. 3 — James T. Stephens, Lorain County, Chairman; Thomas E. Fox, Warren County; Maurice M. Kane, Darke County; Walter A. Daniel, Seneca County; P. A. Overstreet, Lucas County; William F. Boukalik, Cuyahoga County; G. E. DeCicco, Mahoning County; Carl A. Lincke, Carroll County; J. H. Kennedy, Licking County; Chester H. Allen, Scioto County; Charles W. Pavey, Franklin County.

Tellers and Judges of Election — S. A. Burroughs, Ashtabula County, Chairman; Clarence L. Johnson, Hardin County; William J. Neal, Fulton County; Mark G. Herbst, Stark County; Lewis W. Coppel, Ross County; Emil J. Meckstroth, Erie County.

Nominating Committee Elected

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

First District — Charles A. Sebastian, Hamilton County.

Second District — Roger C. Henderson, Greene County.

Third District — Fred P. Berlin, Allen County.

Fourth District — William J. Neal, Fulton County.

Fifth District — Paul A. Mielcarek, Cuyahoga County.

Sixth District — Jack Schreiber, Mahoning County.

Seventh District — Crist G. Strovilas, Jefferson County.

Eighth District — Carl E. Spragg, Muskingum County.

Ninth District — Thomas W. Morgan, Gallia County.

Tenth District — Lewis W. Coppel, Ross County.

Eleventh District — William R. Graham, Huron County.

Dr. Howard then announced that under the system of rotation approved by the House of Delegates in

1963, the chairman of the committee this year would be the nominee from the Sixth District, Dr. Jack Schreiber, Mahoning County.

Introduction of Resolutions

Dr. Howard then called for the introduction of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting should be read by title only for referral. Twenty-two resolutions were read by title only and referred to the resolutions committees.

New Resolutions Presented

Dr. Howard then called for the presentation of new resolutions. The following resolutions by consent of two-thirds of the delegates present, were accepted for consideration by the House and referred to the Resolutions Committees:

RESOLUTION NO. 23
Prior Authorization for Elective Surgery
(By the Academy of Medicine of Cleveland)

WHEREAS, The Ohio Department of Public Welfare has approved a regulation requiring prior authorization from the State Medical Consultation Unit before any type of elective or nonemergency surgery is performed on welfare recipients, and

WHEREAS, This stipulation has been temporarily rescinded so that a more feasible system of prior authorization can be devised, and

WHEREAS, Such stipulations would interfere with the physician's judgment of when surgery should be performed, and

WHEREAS, Such interference may be harmful to the patients, e.g., neoplastic disease requires early surgical attack but is "nonemergency" unless complications occur, and the patient would be adversely affected by any unnecessary delay, and

WHEREAS, Such delay for patients who are beneficiaries of the Ohio Department of Public Welfare are not present for private patients thus setting a double standard for medical care; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association vehemently oppose *any* attempts at instituting this regulation in any form whatsoever.

RESOLUTION NO. 24
Pollution of Lake Erie
(By the Fourth Councilor District)

WHEREAS, Pursuant to the fact that the U. S. Army Corps of Engineers has proposed and avowed their intention at a public hearing to dredge the Rouge River and to dump the dredgings in the western end of Lake Erie, further adding to the pollution of this lake; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association protest this decision of the U. S. Army Corps of Engineers in further polluting Lake Erie; AND BE IT FURTHER

RESOLVED, That the Ohio State Medical Association offer its aid wherever possible toward preventing the pollution of Ohio lakes and streams.

RESOLUTION NO. 25
Wilbur J. Cohen and the U. S. Department of Health, Education, and Welfare
(By Columbus Academy of Medicine)

WHEREAS, Wilbur J. Cohen has been nominated for the powerful position of Secretary of the U. S. Department of Health, Education, and Welfare, and

WHEREAS, Wilbur J. Cohen has, for more than 30 years, constantly worked for a socialistic national health service, and

WHEREAS, His ideology regarding medicine and other matters prevents his impartial administration of this vital Department, and

WHEREAS, His administration of Public Law 89-97 has, in our experience, failed to follow the stated intent of Congress, and

WHEREAS, Wilbur J. Cohen has repudiated in writing singular portions of the Department's February, 1967 "Report to the President on Medical Care Prices," and

WHEREAS, The circumstances surrounding the confirmation of his appointment as Undersecretary of Health, Education, and Welfare are open to question; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association notify the Senate of the United States and the President of the United States that the Ohio State Medical Association objects to the appointment of Mr. Cohen, as Secretary of the Department of Health, Education, and Welfare, because his policies and programs will not provide the best health care to the citizens of this country; and BE IT FURTHER

RESOLVED, That the Ohio Delegation to the American Medical Association be instructed to introduce, at the AMA 1968 Annual Convention, a similar resolution for consideration by the AMA House of Delegates.

RESOLUTION NO. 26
Group Practice of Medicine
(By the Stark County Medical Society)

WHEREAS, Under the guise of promoting experimentation in consumer-controlled group practice of medicine, certain spokesmen for the Federal Government and for labor are flooding the country with propaganda designed to regiment physicians in a system of labor and/or government controlled closed-panel practice of medicine and,

WHEREAS, This proposed "group practice of medicine" permits no free choice of physician nor fee for service and,

WHEREAS, This concept of group practice on a capitation basis places physicians in a minority status with no prerogative of determining medical policy and,

WHEREAS, For many years such experiments in the practice of medicine in other countries wherein medical practice has been government controlled have invariably led to deterioration in the quality and exhorbitant increases in the cost of medical care and,

WHEREAS, This type of practice is not in accord with the nine Principles of Health Care formulated by the House of Delegates of the Ohio State Medical Association and later adopted and reaffirmed by the House of Delegates of the AMA; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association record itself as being opposed to the group practice of medicine when dominated by labor union and/or government and/or nonmedical consumers and, BE IT FURTHER

RESOLVED, That the Ohio State Medical Association continue to espouse the private, fee-for-service practice of medicine forcefully, actively, and at all times as the best method of preventing the complete socialization of medicine in the United States and, BE IT FURTHER

RESOLVED, That the delegates of the Ohio State Medical Association be instructed to request the House of Dele-

gates of the AMA to adopt and implement this resolution as an unequivocal statement of policy.

These resolutions were duly referred to the reference committees, as were the following reports on resolutions passed by the House of Delegates at the 1967 Annual Meeting:

AMENDED RESOLUTION NO. 6 (1967)
Payment of Dues

WHEREAS, A number of County Medical Societies in the larger metropolitan areas are experiencing budgetary problems which include expenses for the collection of dues of the Ohio State Medical Association and the American Medical Association, NOW, THEREFORE, BE IT

RESOLVED, That The Council of the Ohio State Medical Association be directed to study the problem of dues collection in its entirety and make appropriate recommendations, AND BE IT FURTHER

RESOLVED, That The Council be instructed to notify all County Medical Societies of a hearing or hearings that are to be scheduled before a final policy is adopted in reference to the collection of dues.

Interim Committee Report on Resolution 6 — 1967

Members of the Auditing and Appropriations Committee heard witnesses from Hamilton, Summit, Montgomery, Franklin, and Jefferson Counties and reviewed communications from Mahoning and Lucas Counties. The representatives from Hamilton and Summit Counties expressed concern about cost factors and financing problems. Consideration of reimbursement for dues collection was requested by Hamilton, Summit, and Lucas Counties. Hamilton County requested that installment billing be authorized. Only Hamilton, Summit, and Lucas Counties expressed opposition to current billing procedures, while Franklin, Jefferson, and Mahoning Counties and the late Mr. R. Freeman, Executive Secretary, representing Montgomery County, found no objection to the present system of having a county bill for local, state, and national association dues.

The committee felt that insufficient evidence was presented to justify alteration of current billing mechanisms to permit reimbursement to a county for collection of dues or to compensate a county for the time required to explain the dues statement. Explanation of dues is a part of the internal public relations of any organization.

The Auditing and Appropriations Committee, therefore, recommends that The Council adopt the following four principles in response to the request of the House of Delegates Resolution:

1. That there be no separate billing for county, state, and national dues.
2. That combined billing of county, state, and AMA dues by the OSMA not be considered at this time, but that the operation of such a program in two neighboring states be observed closely by The Council.
3. That the cost of dues collection be borne by the county societies as stipulated in their charters.
4. That the timing or method of dues collection can be programmed by a county society as best suits the needs of its members, provided that delinquent dues payments to OSMA and AMA do not jeopardize full membership representation in those bodies.

The foregoing report was approved by the OSMA Council on February 18, 1968.

SUBSTITUTE RESOLUTION NO. 7 (1967)
Group Malpractice Coverage

WHEREAS, This House of Delegates recognizes the increasing difficulty of some of its members in obtaining adequate professional liability insurance NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates requests The Council of the Ohio State Medical Association to investigate the feasibility of group liability insurance for members of the Ohio State Medical Association, AND BE IT FURTHER

RESOLVED, That a progress report be presented at the 1968 Annual Meeting.

Interim Committee Report on Resolution 7 — 1967

The OSMA Committee on Insurance made inquiry to the following Insurance Companies concerning their interest in providing group malpractice insurance coverage to members of the OSMA:

1. The Shelby Mutual Insurance Co.
2. The St. Paul Insurance Cos.
3. Fireman's Fund American Life Insurance Cos.
4. The Home Insurance Co.
5. Aetna Life and Casualty
6. American Mutual Liability Insurance Co.
7. Continental Casualty Co.
8. Insurance Company of North America
9. Medical Protective
10. Pacific Indemnity
11. U. S. Fidelity & Guaranty Co.
12. The Travellers Insurance Co.
13. The Employees' Fire Insurance Co.

Responses were received from 10 of the 13 inquiries. Without exception the responding companies were not interested in issuing Group Malpractice coverage to members of the Ohio State Medical Association by virtue of membership in the Association. This fails to solve the problem of the physician who has had his professional liability insurance canceled, for any reason. Several insurance companies are interested in providing malpractice insurance to OSMA members through an OSMA endorsed and sponsored plan. But these insurance companies reserve the right to individually select or reject each applicant. And further, they reserve the right to discontinue coverage on an individual basis for good and sufficient reasons.

Since any OSMA endorsed and sponsored insurance program must have sufficient interest and participation to establish and maintain a sound program, the OSMA Council has authorized a survey of its members to determine the extent of the problem and interest in such an insurance program. The survey is to be carried out in connection with an OSMAgram. Interest in an OSMA endorsed and sponsored program is to be indicated on a return postal card.

At the present time, at least, 13 state medical associations sponsor and endorse malpractice insurance for its members. They are: (1) Minnesota (2) Georgia (3) North Carolina (4) Washington, D. C. (5) Virginia (6) Illinois (7) Florida (8) California (9) New Jersey (10) New York (11) Oregon (12) Washington (13) Tennessee.

The Council of the Ohio State Medical Association hereby requests permission from the OSMA House of Delegates to proceed with the indicated action resulting from the OSMAgram postal card survey.

(The Council referred Resolution 17 (1967) to the Committee on Insurance at the July 26, 1967 meeting. The foregoing report was accepted by The Council at its March 30-31, 1968 meeting for presentation to the House of Delegates.)

RESOLUTION NO. 17 (1967)
Reapportionment for Equitable Representation

The OSMA House of Delegates adopted the recommendation of Reference Committee No. 1 (1967) that Resolution No. 17 NOT be adopted, but the

matter was referred to The Council for study by an appropriate committee. The House of Delegates instructed The Council to report on the matter at the next Annual Meeting.

Text of Resolution 17 — 1967

WHEREAS, American medicine has taken pride in the fact that its local and state organizations are truly representative of the physician-members they serve, and

WHEREAS, Recent judicial rulings have stressed that the representation of voters in legislative councils should by right be equal, and

WHEREAS, Shifts in the general population in Ohio have forced many physicians to concentrate their practices in larger urban centers, and

WHEREAS, Delegate-to-member ratios in the Ohio State Medical Association, formerly quite similar throughout the state, now range from a high of one delegate to 97 members in two counties, to a low of one delegate to one member in one county, making it possible for the voting power of approximately 25 per cent of the membership of the Association to equal the voting power of the remaining 75 per cent, and

WHEREAS, Comparison of delegate-membership ratios in 1966 with those from 1965 indicates that this inequality of representation is increasing, NOW, THEREFORE, BE IT

RESOLVED, That a reapportionment of delegates to the Ohio State Medical Association should be effectuated so that each member is equally represented in the House of Delegates, AND BE IT FURTHER

RESOLVED, That methods be adopted to adjust this apportionment every 5 years so that representation of members remains equal at all times, AND BE IT FURTHER

RESOLVED, That appropriate amendments to the Constitution and Bylaws of the Ohio State Medical Association to effect such equal representation and periodic review be prepared by the legal counsel, under the supervision of The Council of the Association and be presented for action by this House of Delegates at the Annual Meeting in 1968.

Report of Interim Committee on Resolution 17 — 1967

The Council of the Ohio State Medical Association was instructed, by official action of the House of Delegates (Resolution 17, H. O. D. May 15-19, 1967), to establish an appropriate committee to study inequity in representation of individual physicians throughout the state in the House of Delegates and to report on this matter at the next annual meeting (May, 1968).

The following is a report by this special committee of its actions, deliberations, and recommendations to The Council.

In submitting this report to the House of Delegates the committee is fully aware that organizational change fosters controversy and wishes to preface its report by emphatically stating that its recommendations arise from a sincere dedication to enhance and promote (member) physician involvement. The mere correction of inequitable delegate-to-member ratio falls short of challenging physicians into active participation in organized medicine's continuing drive to promote and protect high quality medical care for the citizens of Ohio.

On August 16, 1967, a letter was sent to all county medical society presidents, welcoming suggestions from the counties on reapportionment and redistricting.

Again on October 25, 1967, the chairman of the special committee sent a bulletin to all county medical society secretaries announcing a meeting to be held at the OSMA Headquarters on November 3, 1967. The bulletin stated that any member of the OSMA could present his views. In addition, through the cooperation of the AMA Field Representative, all component organizations of the AMA were polled regarding the ratio of state delegate-to-(state) member.

At the November 3rd meeting the committee interviewed a number of county representatives and reviewed communications from officers of a number of county societies. Among these communications was the scholarly, detailed analysis and recommendations from the Cleveland Academy of Medicine. While highly considered, it was the consensus of committee members present that an increase in physician population which has thus far been the history of all but two Councilor Districts since 1939 would necessitate frequent and confusing readjustments of delegate-to-physician ratios.

On December 9, 1967, the special committee considered the matter of redistricting as an alternative measure. A tentative redistricting plan was formulated. Such a plan while establishing a satisfactory ratio of physician to Councilor and a more equitable distribution of delegates from Councilor Districts than currently appears to exist, presented insurmountable organizational difficulties.

The committee again met February 16, 1968, and after much discussion by the members present concurred in recommending to The Council and to the House of Delegates the following plan for reapportionment and redistricting:

1. The Bylaws (Chapter 4, Section 2) be changed where relevant to redefine the delegate-to-member ratio from 1:100 to 1:75.

2. The Association be redistricted by the establishment of three new Councilor Districts.

3. The Bylaws be changed where relevant to forestall reconsideration of reapportionment until a district membership exceeds 1600 physicians.

4. The Council be instructed to study the establishment of a Field Representative to assist Councilors whose districts are too large to permit them to discharge their duties in an optimum manner.

In a final meeting March 30, 1968, the special committee reviewed and concurred in submitting these above recommendations for Council approval and implementation.

Injected into this deliberation was a lengthy discussion on the philosophical outlook of the Ohio State Medical Association with particular emphasis on the urban-rural aspects of this problem. The House of Delegates, by action, should decide these following points:

1. Shall small member counties be integrated into a larger society attempting to bring the membership of such a society into some minimum number of members, and make a Councilor Society?

2. Shall larger member societies be divided into smaller units?

3. Shall Councilor Districts be utilized as a voting unit or be kept at the present administrative functional unit with or without regard to Delegate/Member proportion within the district for proportional voting strength by districts as well as counties?

4. Shall the Councilor Districts be maintained at widely variant member totals as at present 2503 vs 150, or shall attempts be made within reason of widely separated rural areas to bring this total membership more nearly even?

The Reapportionment Committee of Council, to which was added the redistributive, respectfully submits the above as data, and suggests with The Council's approval that:

1. A discussion be made in the resolution committee on the above suggested points for clarification and;

2. That at least another year be given for further study and testimony regarding this extremely important matter;

3. That County Medical Societies represented at this House of Delegates meeting be urged to participate in this study to their fullest extent.

House Recessed

Following announcements about meetings of the Reference Committees and the second session of the House of Delegates, the House recessed until Thursday evening, May 16.

MINUTES OF SECOND SESSION

The second business session of the House of Delegates of the Ohio State Medical Association at the 1968 Annual Meeting was held on Thursday evening, May 16, at the Netherland Hilton Hotel.

The following guests were introduced by President Howard: Dr. P. J. V. Corcoran, Evansville, Indiana, President-Elect of the Indiana State Medical Association, who addressed the House; the following representatives of the Woman's Auxiliary: Mrs. J. Paul Sauvageot, Akron, President, Mrs. Malachi W. Sloan, II, Dayton, President-Elect, Mrs. Harry L. Fry, Cincinnati, convention chairman, Mrs. Samuel Meltzer, Portsmouth, publicity committee chairman; Dr. Robert S. Martin, Zanesville, Dr. Robert E. Tschantz, Canton, Dr. H. T. Pease, Medina, Past Presidents of the Association; Dr. Philip B. Hardymon, Columbus, former Treasurer of the Association.

Mr. David Weihaupt, Chicago, field service representative for the American Medical Association, was introduced by the President and Mr. Weihaupt was commended by the President on his accomplishments in furthering communications and good relationships between the AMA and Ohio physicians.

AMA Woman's Auxiliary President Addresses the House

Mrs. Karl Ritter, Lima, Ohio, President of the Woman's Auxiliary to the American Medical Association, was introduced and she addressed the House of Delegates.

Report of Credentials Committee

Dr. Chester J. Brian, Preble County, Chairman of the Credentials Committee, reported 153 delegates were seated and eligible to vote. Also present were alternate delegates and other guests.

President-Elect Addresses the House

Dr. Theodore L. Light, Dayton, President-Elect of the Association, presented a brief address to the House of Delegates.

Executive Session of the House

A motion to dissolve the House and to reconvene as a committee of the whole in executive session was defeated.

Dr. Clarence L. Huggins, Jr., Cuyahoga County, asked for the privilege of speaking to the House of Delegates. A motion that he be permitted the privilege of the floor for the discussion of Dr. Light's address was duly seconded and carried.

At this time President Howard declared the House to be in executive session. During the executive session, on motion by Dr. Schrieber, seconded by several and carried, Dr. Light's position as President-Elect was reaffirmed by the House of Delegates.

President Howard then adjourned the executive session and reconvened the House in regular session. He asked the delegates to respect the confidentiality of the executive session.

Committee on President's Address

Dr. Howard called for a report of the Reference Committee on the President's Address, which was presented by Dr. Jack Schreiber, Mahoning County, chairman of the committee. The report read as follows:

"The reference committee on the President's Address considered it a singular honor to be asked to evaluate the splendid Presidential address.

"Dr. Howard addressed himself to the overriding problem which troubles and concerns every practitioner in Ohio and in the nation. That problem is the threat to the private practice of medicine and Dr. Howard displayed unusual perception and unique comprehension.

"He spoke directly to the point. He was especially forthright in his unalterable stand against those who would restructure medicine. The committee commends the President for this. We commend him further for his courage, particularly his courage to be specific. He said things that needed to be said and he said them well.

"His address brought into sharp focus the multiplicity of the problems which face our profession. With documentation and first-hand knowledge he outlined brilliantly the overall threat to the private practice of medicine. He was thus able to give this House of Delegates the 'big picture' and the frame around that picture.

"Dr. Howard very ably pointed out that the threat of socialized medicine lies not only in Washington, but within the very ranks of our own profession. He displayed courage in identifying the four physicians holding appointive positions of importance in the organization of medicine — physicians who publically endorsed and warmly embraced the newly appointed Secretary of Health, Education, and Welfare.

"The President did more than identify the problem. He urged the continuation of direct billing, and individual responsibility in dealing directly with our patients. Dr. Howard also urged the members of this House and all physicians in Ohio to keep themselves informed of the increasing weight of evidence of the plans to reshape medical practice.

"In summary, Dr. Howard said for all of us here the things that needed to be said. In this he was refreshing. Refreshing, because he was brief, concise, and he was unswervingly loyal to the private practice of medicine. The committee was particularly impressed with his closing remarks. He said, 'I am convinced that it is time for organized medicine and private practice to speak up, loudly, clearly, and

repeatedly. I therefore charge this House of Delegates, the officers, The Council and the members of OSMA to oppose actively the socialization of medicine, both as citizens and as doctors.'

"This truly outstanding address gave us new strength and made us proud to be Ohioans — and proud to be free physicians.

"Mr. President, I move the adoption of this report.

"Members of the committee are as follows: Robert A. Bruce, Montgomery County; Charles A Browning, Logan County; Cyrus R. Wood, Ottawa County; H. William Porterfield, Franklin County; Jack Schreiber, Mahoning County, Chairman."

On motion made and seconded, the House of Delegates, by official action, approved the report of the Committee on President's Address.

Reference to Original Text of Resolutions

The original texts of most of the nonemergency resolutions considered at the 1968 Annual Meeting are printed beginning on pages 491 of the April, 1968, issue of *The Ohio State Medical Journal.*

Report of Resolutions Committee No. 1

Dr. James C. McLarnan, Knox County, reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"Resolutions Committee No. 1 held hearings on ten resolutions, two of which were emergency resolutions submitted for consideration at the first session of the House of Delegates. Discussion was thorough and informative. The tenor of the remarks of all persons who appeared before the Committee was that their primary concern was with the continuation of good patient care. All other items discussed were of secondary importance. The Committee gave thoughtful consideration to all testimony brought before it.

RESOLUTION NO. 8
Insurance for High School Athletes
(By the Madison County Medical Society)

"The first resolution heard was Resolution No. 8. The discussion established the fact that many secondary schools are not able, for financial and other reasons, to obtain adequate insurance protection for their student-athletes.

"The need for such insurance was shown by the fact that there had been several athletic injuries within the State in the past several years where insurance benefits were not adequate, or not present at all, thereby causing hardship to the parents of these injured individuals. It was also brought to the attention of the Committee that there were no minimum standards for responsibilities of the schools to provide for medical care for injured athletes, or for insurance to cover these medical care costs.

"With this in mind, the Committee presents the following Substitute Resolution No. 8.

SUBSTITUTE RESOLUTION NO. 8
Payment of Medical Care for Student-Athletes

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association recommends that the Insurance Committee of the Ohio State Medical Association formulate adequate standards for payment of medical care costs for injured student-athletes in the State of Ohio, and

BE IT FURTHER RESOLVED, That The Council of the Ohio State Medical Association be directed to request the Ohio Department of Education to set up minimum standards for insurance to be provided by local Boards of Education to pay medical care costs for injured student-athletes.

"Mr. President, I move the adoption of Substitute Resolution No. 8."

By official action, the motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 8 be adopted, was carried.

RESOLUTION NO. 22
Reorganization of Health Agencies
(Submitted by H. William Porterfield, M. D., a Delegate, Columbus Academy of Medicine)

"The Committee next considered Resolution No. 22.

"It was the consensus of the Committee that this resolution deserves adoption but the Committee exercised its editing authority and substitutes the word 'independent' for the word 'free-standing' in the first Resolve.

"The resolution now reads:

AMENDED RESOLUTION NO. 22
Reorganization of Health Agencies

WHEREAS, Federal tax spending includes billions of dollars for scores of federally assisted medical and health projects; and

WHEREAS, There are multiple, overlapping federal and state agencies making funds and grants available for studies, projects, and programs; and

WHEREAS, Many of these activities are funded or approved by various agencies of the State of Ohio; and

WHEREAS, This tends to create confusion, misunderstanding, duplication, and waste of federal and state tax monies. THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association exert every effort to achieve in this state the organization and implementation of an independent state agency to coordinate and administer the approval of all such grants, funds, and projects, AND BE IT FURTHER

RESOLVED, That this Association and other similarly established and recognized scientific associations in Ohio be responsible for establishing the policies and administrative procedures of this agency, AND BE IT FURTHER

RESOLVED, That the Ohio delegation to the American Medical Association be instructed to present to that Association's House of Delegates a resolution directing that the AMA use every means and resource available to achieve the establishment of a separate U. S. Depart-



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Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

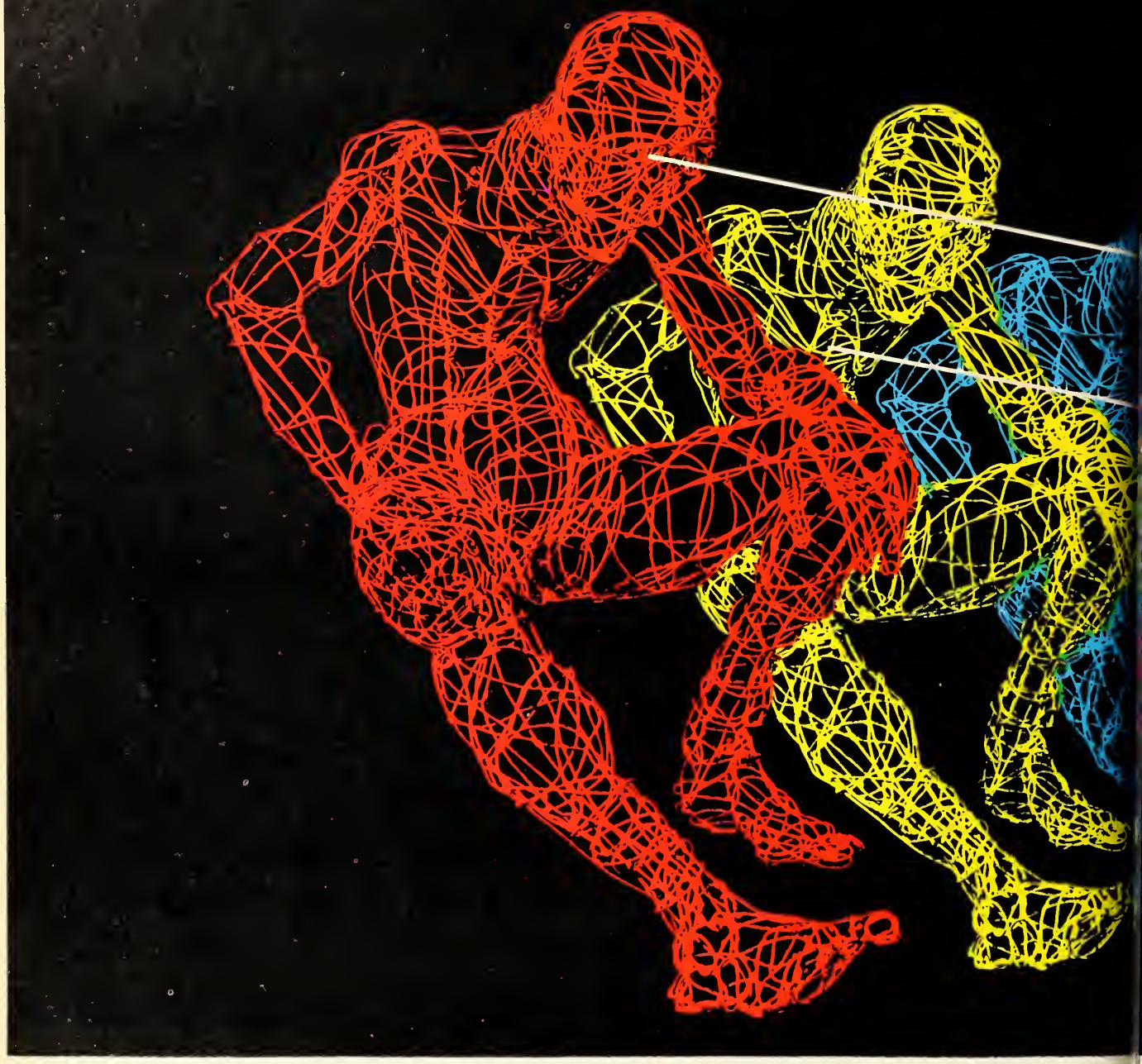
In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

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Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
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Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

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Precautions: Anemia is a manifestation that requires appropr investigation to determine its cause or causes.

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extremely rare instances, skin rash suggesting allergy has ved oral administration of liver-stomach material. Instances parent allergic sensitization have also been reported after dministration of folic acid.

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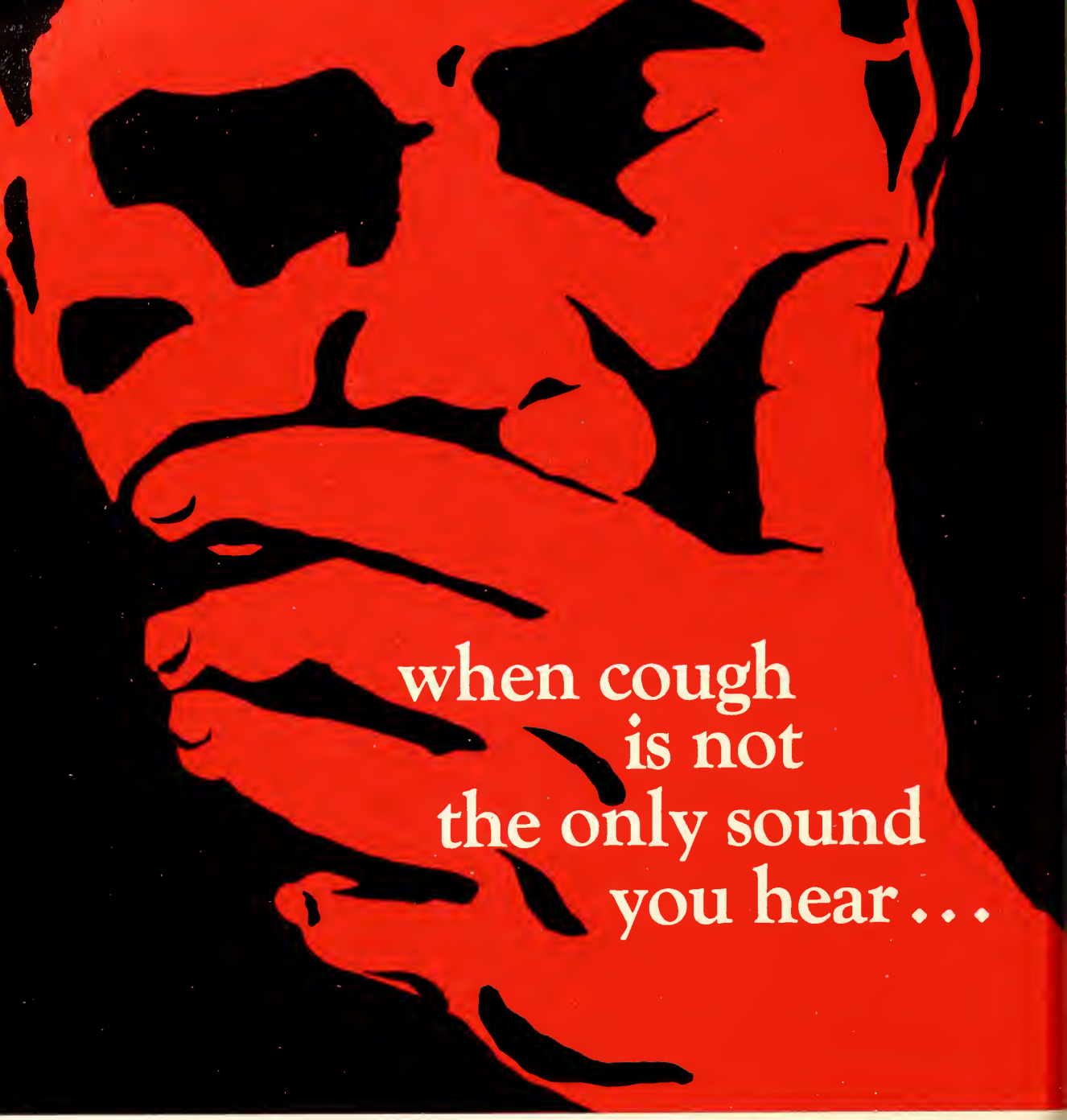
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Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

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ment of Health of rank and status equal to the other Federal Departments of cabinet rank, AND BE IT FURTHER

RESOLVED, That the AMA and every component society use every means and resource available to establish single state health agencies for the implementation of all health programs within the individual state.

"The Committee unanimously recommends the adoption of Amended Resolution No. 22 and Mr. President, I so move."

By official action, the second Resolve paragraph of Amended Resolution No. 22 was deleted. The House then referred the entire resolution to the Ohio State Medical Association Council for further study, with a request that a report be presented at the next meeting of the House.

RESOLUTION NO. 13
Permission for Autopsy
(By the Knox County Medical Society)

WHEREAS, The performance of postmortem examinations in other than medicolegal circumstances, is recognized as a valuable aid in postgraduate medical education, and

WHEREAS, It is necessary to obtain permission for such examination from the "next of kin" of the deceased person, and

WHEREAS, It is often difficult to determine who is the "next of kin," and

WHEREAS, There is no statute of the State of Ohio defining "next of kin" for purposes of giving permission of autopsy, thus making it often times impossible to be certain that valid permission has been obtained, NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association request The Council of the Ohio State Medical Association, with the aid of its staff and its legal counsel, to cause legislation to be introduced at the next session of the Ohio Legislature to define "next of kin" for the purpose of giving permission for postmortem examination.

"There was no objection to Resolution No. 13. The Committee unanimously recommends its adoption, and Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 13 be adopted as introduced, was carried.

RESOLUTION NO. 3
Usual and Customary Fee, Ohio Welfare Department
(By the Erie County Medical Society)

"Resolution No. 3 provoked long and illuminating discussion.

"The Committee was informed that, due to lack of adequate communication between the Ohio Department of Public Welfare, the Ohio State Medical Association officers and staff, and the membership of the Ohio State Medical Association, an apparent injustice has been done to the Ohio Department of Public Welfare. It was stated that the Department, in 1967, did in fact submit a request for adequate funds to cover the entire proposed medical assistance program. The request for additional funds, which would have provided 100 per cent medical assistance, was declined by the Governor's office before this request was transmitted to the Ohio Legislature in the form of a budget.

"In further discussion, the Committee feels that the Proposed Resolution No. 3 would add nothing to the principles adopted by the House of Delegates in redrafted Amended Resolution No. 28, 1967, from which I quote:

Redrafted Amended Resolution No. 28 (1967)

RESOLVED, That . . . this Association insists that, whenever a Governmental Agency contracts to pay for medical services, the full usual, customary, and reasonable fee be provided

"The Committee wishes to reaffirm this principle and, in so doing, requests that Resolution No. 3 be not adopted. Mr. President, I move that this principle be reaffirmed and that Resolution No. 3 be not adopted."

By official action, the motion to accept the recommendation of the committee, namely, that the paragraph from redrafted amended Resolution No. 28 (1967) be reaffirmed and that Resolution No. 3 be NOT adopted, was carried.

RESOLUTION NO. 23
Prior Authorization for Elective Surgery
(By the Academy of Medicine of Cleveland)

"Resolution No. 23, which was submitted as an emergency resolution by the delegates of Cuyahoga County, was next considered. The Committee feels that this is a proper resolution for action, but would correct the first 'Whereas' to read 'County Welfare Department' rather than 'State Medical Consultation Unit,' as this is the agency designated in the Handbook for Professionals distributed by the Ohio Department of Public Welfare and dated March, 1968.

"Further editorial changes were made in the fourth 'Whereas' and in the 'Resolve' section for clarity and conciseness. The Committee submits the following amended resolution:

AMENDED RESOLUTION NO. 23
Prior Authorization for Elective Surgery

WHEREAS, The Ohio Department of Public Welfare has approved a regulation requiring prior authorization from the County Welfare Department before any type of elective or nonemergency surgery is performed on welfare recipients; and

WHEREAS, This stipulation has been temporarily rescinded so that a more feasible system of prior authorization can be devised; and

WHEREAS, Such stipulations would interfere with the physician's judgment of when surgery should be performed; and

WHEREAS, Such interference may be harmful to some patients and the patients would be adversely affected by any unnecessary delay; and

WHEREAS, Such delay for patients who are beneficiaries of the Ohio Department of Public Welfare is not present

for private patients, thus setting a double standard for medical care, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association actively oppose any attempts at reinstituting this regulation in any form whatsoever.

"Mr. President, I move the adoption of Amended Resolution No. 23."

By official action, the motion to accept the recommendation of the Committee, namely, that Amended Resolution No. 23 be adopted, was carried.

RESOLUTION NO. 10
Proposed Amendment to Medicare Law

(By the Huron County Medical Society)

"This resolution provoked little discussion.

"It is the feeling of your Committee that this resolution merely restates a position which has been historically taken by your House of Delegates and the AMA, and which adds no new principles to our philosophy toward medical assistance. The Committee wishes to reaffirm the principle; namely, that any public assistance be given only to those who show financial need for such assistance, and recommends that Resolution No. 10 be not adopted.

"Mr. President, I do so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 10 be NOT adopted, was carried.

RESOLUTION NO. 15
Truth in Labeling

(By the Summit County Medical Society)

"Resolution No. 15 was next discussed.

"It became evident that in certain areas of the State third party contractors for medical care payments have imposed administrators between the doctor and the patient for the purpose of setting medical fees. The Committee feels that the tradition of the medical profession of having a relationship solely with the patient and not with third party carriers should be preserved. The Committee objects to methods used by some insurance companies in attempting to interfere with his relationship by the arbitrary setting of a fixed fee through the guise of providing full payment for physicians' services.

"The Committee again amended the resolution for purposes of clarity only, and submits the following:

AMENDED RESOLUTION NO. 15
Truth in Labeling

WHEREAS, Insurance carriers, groups, and individuals are making contracts designed to provide full payment for physicians' services; and

WHEREAS, The physician-supplier of such services is not a party to such contracts, let alone as a contractor; and

WHEREAS, The end result of the actions of these insurance carriers and groups is to impose unilaterally a fixed fee; and

WHEREAS, The administrators of these contracts attempt to establish that individual fees are not proper because they do not conform to the maximum predetermined by the carriers; and

WHEREAS, The group purchaser is misled into a false impression of his level of protection and of his level of personal liability for full payment of professional fees as billed; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association regards prepaid medical care contracts as indemnification programs only, THEREFORE, BE IT

RESOLVED, That The Council of the Ohio State Medical Association request, in the public interest, a full review by the Superintendent of Insurance, State of Ohio, of all contracts now in force and under his jurisdiction that allege to provide full payment of physicians' fees, and of related sales literature, descriptive pamphlets and booklets, to assure truth in labeling of such plans as indemnification only.

"Mr. President, I move the adoption of Amended Resolution No. 15."

By official action, the motion to accept recommendation of the committee, namely, that Amended Resolution No. 15 be adopted was carried with an amendment from the floor changing the second Whereas to read as indicated in *italics*.

RESOLUTION NO. 16
Hospital-Based Physicians

(By the Summit County Medical Society)

"This resolution provoked no adverse discussion.

"The Committee feels that this resolution is a worthy follow-up to previous resolutions recommending the implementation of direct billing and collecting of fees by hospital-based physicians, and unanimously recommends its adoption.

"Mr. President, I so move."

The House amended the WHEREAS paragraph of Resolution No. 16 to read as follows:

WHEREAS, With the unusual initiative and some personal difficulty the members of this Association practicing hospital-based specialties have contributed significantly to the policy of the OSMA regarding billing the patient directly in the same manner as other physicians.

The amended resolution, as approved, reads as follows:

AMENDED RESOLUTION NO. 16
Hospital-Based Physicians

PREAMBLE

It is our intention to express the appreciation and respect of the medical profession in Ohio to those hospital-based physicians who have implemented the separate establishment, billing, and collecting of their professional fees from the charges of hospitals.

WHEREAS, With unusual initiative and some personal difficulty the members of this Association practicing hospital-based specialties have contributed significantly to the policy of the OSMA regarding billing by separating their charges and billing the patient directly in the same manner as other physicians; THEREFORE, BE IT

RESOLVED, That the House of Delegates at its annual meeting, 1968, commend these members for their ex-



Past Presidents of the Association were honored at a dinner meeting of The Council on Tuesday evening of the Annual Meeting week. Those present, from left are:

Front Row: Dr. George A. Woodhouse, Dr. Laurence C. Meredith, Dr. Robert E. Howard, now the Immediate Past President, Dr. Merrill D. Pugh, and Dr. Horatio T. Pease;

Second Row: Dr. Henry A. Crawford, Dr. L. Howard Schriver, Dr. Frank H. Mayfield, Dr. Parke D. Smith, Dr. Carl A. Lincke, and Harve M. Clodfelter;

Third Row: Dr. Robert E. Tschantz; Dr. George W. Petznick, Dr. Edwin H. Artman, and Dr. Robert S. Martin. Not shown in the picture but present for other Annual Meeting functions was Dr. Richard L. Meiling, Columbus.



Ohio's Delegation to the American Medical Association met during the Annual Meeting to discuss plans for the San Francisco Convention. Some of the Delegates and Alternates are shown.

emplary contribution to the best interest of the profession and the public.

Subsequently, by official action, the motion to accept the recommendation of the committee, namely, that Amended Resolution No. 16 be adopted, was carried, with the above amendment added by the House.

RESOLUTION NO. 19 AND RESOLUTION NO. 26
Group Practice of Medicine

"These resolutions, both concerning 'group practice of medicine,' were discussed jointly. The Committee feels that the point can best be made by minor changes in Resolution No. 26. The Committee submits for your consideration the following:

AMENDED RESOLUTION NO. 26
Nonmedical Controlled Practice of Medicine

WHEREAS, Under the guise of promoting experimentation in consumer-controlled group practice of medicine, certain spokesmen for the Federal Government and for labor are flooding the country with propaganda designed to regiment physicians in a system of nonmedical controlled closed-panel practice of medicine; and

WHEREAS, This proposed type of "group practice of medicine" permits no free choice of physican nor fee for service; and

WHEREAS, This concept of group practice on a capitation basis places physicians in a minority status with no prerogative of determining medical policy; and

WHEREAS, For many years such experiments in the practice of medicine in other countries have invariably led to deterioration in the quality and exhorbitant increases in the cost of medical care; and

WHEREAS, This type of practice is not in accord with the nine Principles of Health Care Formulated by the House of Delegates of the Ohio State Medical Association and later adopted and reaffirmed by the House of Delegates of the AMA, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association continue to oppose nonmedically controlled practice of medicine; and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association continue to espouse the private, fee-for-service practice of medicine forcefully, actively, and at all times as the best method of providing medical care, and, at the same time, preventing the complete socialization of medicine in the United States; and BE IT FURTHER

RESOLVED, That the delegates of the Ohio State Medical Association be instructed to request the House of Delegates of the AMA to adopt and implement this resolution as an unequivocal statement of policy.

"The Committee feels this amended resolution contains the principles basic to both resolutions which have been submitted, and, therefore, recommends that Resolution No. 19 not be adopted and that Amended Resolution No. 26 be adopted.

"Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 19 be NOT adopted and that Amended Resolution No. 26 be adopted, was carried.

RESOLUTION NO. 17 (1967)
Reapportionment for Equitable Representation

"The last item discussed by the Resolutions Committee No. 1 was the Report to 1968 House of Delegates on Resolution No. 17, 'Reapportionment for Equitable Representation' — (1967). The Committee was asked to discuss certain questions proposed by the Committee of The Council which considered this resolution. The discussion brought forth the following consensus of those who appeared before the Committee:

"(1) If reapportionment for more equitable representation be brought about, there was considerably more sentiment toward consolidation of smaller member counties into larger groups than there was for subdivision of the larger member societies.

"(2) Due to geographic difficulties, it was felt that Councilor Districts could not be changed to bring them into equal member representation, and, therefore, Councilor Districts should continue as administrative functional units rather than as equitable voting units.

"(3) There was little sentiment expressed toward the need for a larger number of Councilors in order to provide more equitable representation of OSMA members. It was clearly brought to the Committee's attention that each Councilor acted for the good of the State as a whole rather than presenting a provincial attitude from his District only.

"Resolutions Committee No. 1 recommends:

"(1) That at least another year be given for further study and testimony regarding this matter.

"(2) That the discussions at the hearings be used in the committee's deliberations.

"(3) That county medical societies, especially those representing the smaller counties, be urged to participate in this study to a fuller extent than in the past year.

"Mr. President, I move the adoption of these recommendations."

By official action, the recommendations of Resolutions Committee concerning Resolution No. 17 (1967) were adopted by the House of Delegates. **See Page 820 for text of resolution.**

"I wish to express my personal appreciation to the members of the Committee for their thoughtful consideration of the matters presented and for their wisdom.

"I wish also to acknowledge the helpful services of the executive staff and secretarial staff of the Ohio State Medical Association for their invaluable help.

"The members of the Committee are: Carl A. Minning, Clermont County; Jerry L. Hammon, Miami County; Dwight L. Becker, Allen County; Robert A. Borden, Sandusky County; William V. Trowbridge, Cuyahoga County; Thomas W. Jackson, Summit County; Robert E. Rinderknecht, Tuscarawas County; Chester Swett, Fairfield County; Albert M.

Shrader, Pike County; William R. Graham, Huron County; James C. McLarnan, Knox County, Chairman."

By official action, the report of Resolutions Committee No. 1 as a whole, as amended, was approved by the House of Delegates.

Report of Resolutions Committee No. 2

Dr. Frederick P. Osgood, Lucas County, reported for Resolutions Committee No. 2, of which he was chairman. The report read as follows:

"Resolutions Committee No. 2 was asked to hear the discussion on seven resolutions and a report submitted by the OSMA Auditing and Appropriations Committee. There was very active attendance and participation by many members of the Ohio State Medical Association. The committee is indebted to the observations and discussions presented by these members.

RESOLUTION NO. 1
Ohio Medical Indemnity, Inc.

"This resolution was submitted by the Mahoning County Medical Society. After listening to discussions from numerous members from the floor, the committee agreed with the following conclusions which had been arrived at by the ad hoc committee in 1964:

"1. The medical profession cannot divorce itself from economic and social trends in this day. It must concern itself with health care insurance and provide continuing leadership in improving it.

"2. Ohio Medical Indemnity is continuing effectively to fulfill the purposes for which it was conceived, and is doing so on a sound financial basis.

"3. The need for its operation still exists.

"For the reasons given above, the committee recommends that Resolution No. 1 be not adopted and, Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 1 be NOT adopted, was carried.

RESOLUTION NO. 6
Composition of AMA Council on Medical Education

"Resolution No. 6 was submitted by the Trumbull County Medical Society. There has been over the past many years action inspired by the Ohio State Medical Association at the American Medical Association level in accordance with the sense of this resolution. Your committee wishes to alter the resolution in accordance with this past activity and hereby submits the following substitute resolution:

SUBSTITUTE RESOLUTION NO. 6
Composition of AMA Council on Medical Education

WHEREAS, Training programs are conducted by the staff members of individual hospitals, and

WHEREAS, Many nonuniversity affiliated hospitals can provide a clinical program as successfully as a university hospital, and

WHEREAS, The composition of the Council on Medical Education of the American Medical Association comprises a membership consisting heavily of medical school faculty or former faculty providing thus for a situation which can possibly discriminate against nonuniversity affiliated hospitals, NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association continue to encourage its delegates to the American Medical Association to continue to urge the trustees to submit names for the Council on Medical Education which will further this objective, namely, a more equitable representation on the AMA Council on Medical Education by physicians who work in nonuniversity affiliated hospital training programs.

"Mr. President, I move the adoption of Substitute Resolution No. 6."

By official action, the motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 6 be adopted, was carried.

RESOLUTION NO. 7
Proposed Changes in Ohio's Abortion Laws

"The discussion relative to Resolution No. 7, presented by the Academy of Medicine of Cleveland, was restricted to the objectives of the two 'Resolved' paragraphs. The discussion which ensued made it apparent to the committee that while the four Whereas paragraphs of the resolution were very well stated, the Resolve portions should be modified. The committee, therefore, submits the following substitute resolution:

SUBSTITUTE RESOLUTION NO. 7
Proposed Changes in Ohio's Abortion Laws

WHEREAS, The House of Delegates of the American Medical Association at its June 1967 meeting stated that:

> "It is to be considered consistent with the principles of ethics of the AMA for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion," and

WHEREAS, It is probable that new legislation concerning the performance of abortions will be presented to the 1969 session of the Ohio State Legislature, and

WHEREAS, The issue of the indications for therapeutic abortion is a controversial one, with divergence of opinion within the medical profession, and

WHEREAS, The legislators are entitled to a clear, dispassionate, and objective discussion of the issues, and an accurate appraisal of the opinions of all segments of the medical profession in the State of Ohio, THEREFORE, BE IT

RESOLVED, That the members of the Ohio State Medical Association be encouraged by all our State Association publications to make their personal convictions known to their local legislators, AND BE IT FURTHER

RESOLVED, That the Ohio State Medical Association Council be constantly on the alert for the need for an advisory committee should such legislation be introduced.

"Mr. President, I move the adoption of Substitute Resolution No. 7."

By official action, the motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 7 be adopted, was carried.

RESOLUTION NO. 9

Internship Requirement for Physician Licensure in Ohio

"Resolution No. 9 was introduced by the delegate from Madison County. During the discussion on this resolution suggestions were presented for a very thorough survey of the graduates of each of the medical schools in this state, including such things as the actual number their medical school and home town, the length and hospital site of internship, the length and site of residency, and the present site and type of medical practice. It was further suggested that such information as might be made available be published in The Ohio State Medical Journal prior to the OSMA Annual Meeting in 1969. While these suggestions seemed to the committee members to be of great value in surveying the situation, they did not appear pertinent to the resolution.

"For this reason, the committee recommends that Resolution No. 9 be not adopted and, Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 9 be NOT adopted, was carried.

RESOLUTION NO. 14

Shortage of Doctors of Medicine

"Resolution No. 14 was introduced by a delegate from Stark County. The similarity of Resolutions 6, 9, and 14 was apparent to all, but each resolution had certain peculiarities of interest and for this reason has been considered singularly.

"The committee would like to submit an amended resolution which would delete the words 'appears to be' and substitute the word 'is' in the third Whereas paragraph. The committee recommends that the second Resolved paragraph be deleted, inasmuch as it was pointed out that such a punitive measure would be a negative approach and in its stead alter the first Resolved paragraph. The amended resolution will then read as follows:

AMENDED RESOLUTION NO. 14

Shortage of Doctors of Medicine

WHEREAS, A definite shortage of Doctors of Medicine exists in certain areas of Ohio as well as in certain areas of the United States, and

WHEREAS, The medical schools of the United States exert a powerful influence as regards the medical students' choice of medical activities after graduation, and

WHEREAS, The percentage of medical students entering the private practice of medicine is declining annually NOW, THEREFORE, BE IT

RESOLVED, That in appreciation of the unencumbered funds received from the AMA-ERF, each medical school be encouraged to file a report with the House of Delegates of the medical association wherein the medical school is located, as to what programs are being undertaken to present to the students the advantages of the private practice of medicine, AND BE IT FURTHER

RESOLVED, That the Council on Medical Education and the Council on Medical Service of the American Medical Association be requested to pursue a course that will encourage young physicians to enter the private practice of medicine.

"Mr. President, I move the adoption of Amended Resolution No. 14."

By official action of the House, the motion to accept the recommendations of the committee, namely, that Amended Resolution No. 14 be adopted, was carried, with an amendment in the final Resolve paragraph which changed the word "instructed" to "requested."

RESOLUTION NO. 18

Standards for Medical Records

"Resolution No. 18, submitted by the Summit County Medical Society, was discussed freely. It was pointed out that in the fourth Whereas there was an inaccuracy of fact in that the requirements are a brief to be followed rather than a delineation of directives and that the elaboration of these briefs are the prerogative of each individual hospital. It was further pointed out that the regulations established by the Joint Commission on Accreditation of Hospitals are designed to be helpful guidelines. While there presently exists confusion relative to the punitive measures which may be enforced, it was the group consensus that medical staffs still direct the policy on medical records through their various committees. For this reason it was not felt proper to request additional regulations with which we would be encumbered.

"Therefore, the committee recommends that Resolution No. 18 be **not** adopted and, Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 18 be NOT adopted, was carried.

RESOLUTION NO. 21

Physician Members on Hospital Governing Boards

"Resolution No. 21 was submitted by the Academy of Medicine of Columbus and Franklin County. During the discussion it was pointed out that Amended Resolution No. 13, adopted at the 1967 session of this House of Delegates, was a very strong resolution which had directed the delegates to the American Medical Association to present this resolution to the American Medical Association. It was further pointed out that action has been taken by the American Medical Association, the American College of Physicians, and the American College of Surgeons, encouraging hospital boards to include doctors. The present resolution is encouraging more active implementation by the Ohio State Medical Association in this direction.

"The committee was completely in accord with this objective and for this reason recommends the adoption of Resolution No. 21 and, Mr. President, I so move."



Key functions of the House of Delagates are performed by the Reference Committees whose duties are to hear discussions on resolutions presented to the House and make recommendations at the final session. Shown presenting the committees' reports, from left, are Dr. James T. Stephens, Dr. Jack Schreiber, Dr. James C. McLarnan, and Dr. Frederick P. Osgood.



This four-member panel presented the program on "Management of Head and Neck Cancer," under sponsorship of the OSMA Section on Plastic Surgery.



Another panel of experts was this one on "Emergency Room Problems."

By official action, the House amended the Resolve paragraph of Resolution No. 21 as follows: After the word "physicians" insert the words "approved by the medical staff," the approved paragraph to read as follows:

RESOLVED, That the Ohio State Medical Association be directed to encourage through its publications and through the component county medical societies the election and/or appointment of physicians approved by the medical staff, with full voting privileges, to the boards of trustees of hospitals.

The amended resolution, as approved, reads as follows:

AMENDED RESOLUTION NO. 21

Physician Members on Hospital Governing Boards

WHEREAS, Physicians are generally sparsely represented on hospital governing boards; and

WHEREAS, Such lack of representation has led to, and can lead to, unnecessary misunderstandings between medical staffs and hospital governing boards; and

WHEREAS, Most physicians are acutely aware of hospital problems, in many cases more so than nonphysician members of hospital governing boards; and

WHEREAS, Many parochial institutions are modernizing to encourage representation of the laity on their governing boards; and

WHEREAS, The AMA has already approved the principle of having physician members on hospital governing boards; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association be directed to encourage through its publications and through the component county medical societies the election and/or appointment of physicians approved by the medical staff, with full voting privileges, to the boards of trustees of hospitals.

By official action, the House approved Resolution No. 21 as amended.

REPORT ON AMENDED RESOLUTION NO 6, (1967)

Payment of Dues

"Resolutions Committee No. 2 was directed to review the report of the Auditing and Appropriations Committee, which had been submitted to and had received the approval of The Council of the Ohio State Medical Association on February 18, 1968. There was an explanation of the dissatisfaction in one of the districts, but no further discussion or opposition was heard regarding the report. The committee had obviously conducted very fair and thorough hearings.

"Mr. President, we would like to recommend the adoption of the report, and I so move."

By official action, the motion to accept the recommendation of the reference committee with regard to Resolution No. 6 (1967), namely, that the report of The Council and the Auditing and Appropriations Committee be adopted, was carried. See page 819 for text of resolution.

"Mr. President, I move the adoption of the report of Resolutions Committee No. 2 as a whole, as amended.

"The committee is indebted further to the OSMA staff for their assistance in furnishing resource material and in preparing the report. I, personally, would like to extend my thanks for the very cooperative spirit evidenced by the members of the committee. The preparation of this report was made possible pursuant to their diligence.

"Members of the committee are: Daniel V. Jones, Hamilton County; James G. Tye, Montgomery County; H. C. Smith, Van Wert County; Robert A. Irvin, Lake County; Maurice F. Lieber, Stark County; Robert R. Johnson, Coshocton County; Kenneth E. Bennett, Washington County; A. Justin Payne, Lawrence County; Jasper M. Hedges, Pickaway County; Albert B. Huff, Wayne County; Frederick P. Osgood, Lucas County, Chairman."

By official action, the report of Resolutions Committee No. 2 as a whole as amended was adopted.

Report of Resolutions Committee No. 3

Dr. James T. Stephens, Lorain County, reported for Resolutions Committee No. 3, of which he was chairman. The report read as follows:

"Resolutions Committee No. 3 had for consideration nine resolutions and one report from The Council. We were tremendously aided in our deliberations by the effective audience participation during the open hearings. We wish to express our sincere appreciation for this help.

RESOLUTION NO. 2

AAPS Essay Contest

(By the Columbus Academy of Medicine)

RESOLVED, That the Ohio State Medical Association endorse the Essay Contest of the Association of American Physicians and Surgeons with the choice of titles: (1) The Advantage of Private Medical Care, or (2) The Advantages of the American Free Enterprise System.

"This resolution was submitted by the Columbus Academy of Medicine. This has been a traditional resolution before the Association. The Committee unanimously recommends its adoption and, Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 2 be adopted, was carried.

RESOLUTION NO. 4

Amendment to OSMA Constitution and Bylaws Regarding Citizenship of Members

(By the Lorain County Medical Society)

"This resolution was submitted by the Lorain County Medical Society. After a lengthy discussion on the purpose of the resolution, the committee suggests a substitute resolution which reads as follows:

w . . . a new
ernate salicylate product
m Warren-Teed

agan®
agnesium salicylate, W-T)

rticularly offered for the management
hose chronic arthritic and rheumatic
ients with gastrointestinal intolerance
aspirin and other salicylates

magan®

an alternate salicylate

n relief comparable to aspirin





agan may provide effective salicylate
erapy for a substantial number of your
tients who cannot tolerate other salicylates
cause of gastrointestinal irritation.

Magnesium salicylate is recognized as a safe and effective alternate to aspirin. A controlled clinical study showed Magan to be not significantly different from aspirin as an analgesic in the treatment of arthritic patients.[1]

Reports from a private practice experience study indicate that Magan was tolerated by a high percentage of patients judged by their physicians to be unable to take aspirin or other salicylates due to gastrointestinal intolerance.[2]

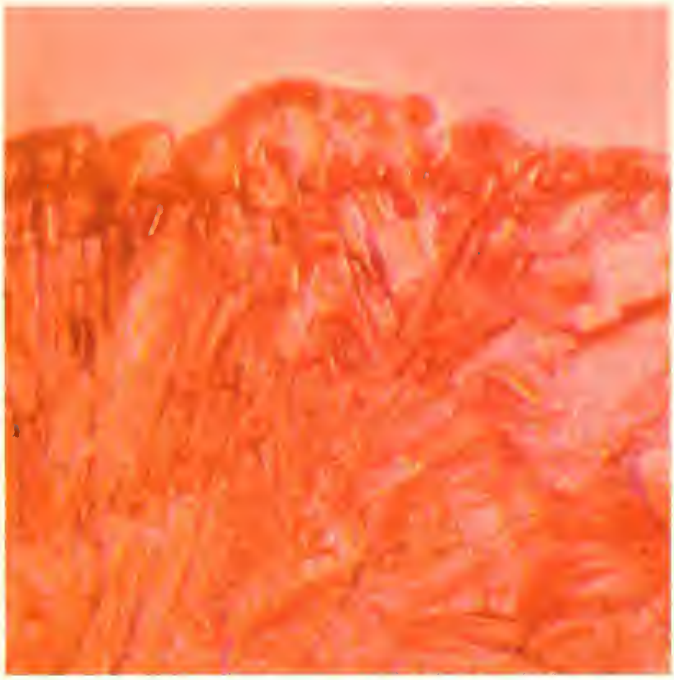
1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing information)

A different salicylate structure—
with no coating, no buffering
and it is sodium free

magan®
(Magnesium Salicylate, W-T)

microphotograph of magnesium salicylate crystals



Composition: Each orange-colored compressed tablet contains 5 grains (approximately 325 mg.) of magnesium salicylate, W-T (salicylic acid equivalent 75%).

Actions, Indications, Uses: The analgesic, anti-inflammatory, and antipyretic effects of MAGAN are similar to those of aspirin and other salicylates. Accordingly, MAGAN is indicated for the treatment of rheumatoid arthritis, osteoarthritis, nonarticular rheumatism such as bursitis, painful-shoulder syndrome, tendosynovitis, fibrositis, and other musculoskeletal disorders. The drug is also useful for the symptomatic relief of pain, aches, and discomfort of headache, neuralgia, minor injuries, dysmenorrhea, common cold and other minor infections of the respiratory tract. MAGAN (Magnesium Salicylate) may be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Contraindications: Because of the danger of hypermagnesemia, MAGAN is contraindicated in cases involving advanced chronic renal insufficiency. MAGAN, as other salicylates, may counteract the effect of uricosuric agents, and should not be prescribed for patients on such drugs.

Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

How Supplied: Bottles of 250 and 1000 tablets.

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SUBSTITUTE RESOLUTION NO. 4

Amendment to OSMA Constitution and Bylaws Regarding Citizenship of Members

WHEREAS, Many physicians are practicing in Ohio who are not citizens of the United States and who are enjoying the privileges and obtaining the benefits of Ohio State Medical Association membership, NOW, THEREFORE, BE IT

RESOLVED, that a prerequisite for membership in the Ohio State Medical Association shall be: United States Citizenship or at least one year of residence in the United States, and an existent valid declaration of intent to acquire U. S. Citizenship in an appropriate court of record; plus a valid license to practice medicine in Ohio, and BE IT FURTHER

RESOLVED, that failure to exercise the announced declaration of intent within five years will result in an automatic termination of membership in the Ohio State Medical Association.

"Mr. President, I move the adoption of Substitute Resolution No. 4."

By official action, the motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 4 be adopted, was carried.

RESOLUTION NO. 5

Registration Fee for Nonmembers Attending OSMA Annual Meeting

(By the Trumbull County Medical Society)

"This resolution was thoroughly discussed in open hearings and given further consideration in executive session of the Committee. While the intent of this resolution is commendable, its practical accomplishments would seem to be minimal and in all probability would result in damaging public relations, therefore the Committee recommends that Resolution No. 5 not be adopted and Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 5 be NOT adopted, was carried.

RESOLUTIONS NO. 11 AND 17

Osteopathic Physicians

"Resolution No. 11, entitled Internships and Residencies in Approved Hospitals for Osteopathic Physicians was submitted by the Huron County Medical Society. Resolution No. 17 Ohio Delegation to the AMA and Osteopathy was submitted by the Summit County Medical Society. These two resolutions were considered together since an amended resolution was adopted by the House in 1965 having the same subject matter and intent as Resolution No. 11 and since the Ohio AMA delegation is actually pursuing the intent of the 1965 resolution. The Committee recommends the adoption of a substitute resolution in place of Resolutions 11 and 17, reading as follows:

SUBSTITUTE RESOLUTION NO. 11

Osteopathic Physicians

WHEREAS, The Ohio State Medical Association House of Delegates in 1965 approved a resolution pertaining to Doctor of Medicine—Doctor of Osteopathy relationship; THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association advocate the policy that osteopathic physicians may be admitted to approved internship programs in Ohio hospitals, and BE IT FURTHER

RESOLVED, that the House of Delegates commend our AMA delegation for its efforts in developing a national policy in the field of Doctor of Medicine—Doctor of Osteopathy relationships and that they be urged to continue these efforts.

"Mr. President, I move the adoption of the substitute resolution."

By official action, the motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 11 be adopted in place of Resolutions 11 and 17, was carried.

RESOLUTION NO. 12

Proposed Amendments to Ohio State Medical Association Bylaws Regarding Effect of Termination of Licensure

(By The Council, Ohio State Medical Association)

WHEREAS, The Ohio General Assembly recently enacted Section 4731.291, Revised Code, to provide for the issuance of a temporary certificate to practice medicine and surgery to persons who hold the degree of Doctor of Medicine and who wish to pursue internship, residency, or fellowship programs in the state (but who have no intention of remaining in the state after the completion of such programs), entitling the holder of such temporary certificate to perform such acts as may be prescribed by or incidental to the internship, residency, or fellowship program; and

WHEREAS, The duration of such temporary certificate is for a period of one year, but may be renewed annually for a maximum of five years; and

WHEREAS, Such temporary certificate may be revoked if the holder thereof engages in practice in the state outside the scope of the internship, residency, or fellowship program for which the temporary certificate has been issued or if the holder thereof is engaged in unethical conduct or has violated Section 4731.22, Revised Code; and

WHEREAS, The Ohio General Assembly recently enacted Section 4731.292, Revised Code, to provide for the issuance of a limited certificate to practice medicine and surgery to persons who hold the degree of Doctor of Medicine (but who are not citizens of the United States), and who desire to practice medicine in state-operated institutions under the supervision of the medical staff of the institution, entitling the holder of such limited certificate to practice medicine in said state-operated institutions under the supervision of the medical staff; and

WHEREAS, The duration of said limited certificate is for a period of one year, but may be renewed up to four times; and

WHEREAS, Such limited certificate may be revoked if the holder thereof engages in practice in this state outside the scope of his certificate or if the holder thereof is engaged in unethical conduct or has violated Section 4731.22, Revised Code; and

WHEREAS, The Bylaws of the Ohio State Medical Association do not provide that a certificate to practice medicine in Ohio shall be a condition of both acquiring and retaining membership in Ohio State Medical Association; NOW, THEREFORE, BE IT

RESOLVED, That subparagraph (b) of the second paragraph of Section 4 of Chapter 1 of the Bylaws of the Ohio State Medical Association be, and the same hereby is, amended to read as follows:

> (b) He must hold a limited, temporary, or unlimited certificate to practice medicine and surgery, issued by the licensing authority of the State of Ohio, which license is, at the time of application for membership in this association, in full force and effect.

BE IT FURTHER RESOLVED, That Chapter 1 of the Bylaws of the Ohio State Medical Association be, and the

same hereby is, amended by the enactment of Section 7, to read as follows:

"Sec. 7. Effect of Expiration, Revocation, or Termination of Certificate. Membership in this association of a member whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be canceled automatically as of the effective date of such expiration, revocation, or termination."

BE IT FURTHER RESOLVED, That Section 7 of Chapter 11 of the Bylaws of the Ohio State Medical Association be, and the same hereby is, amended to read as follows:

"Sec. 7. Effect of Expiration, Revocation, or Termination of Certificate. Membership in a component society of a member of such society whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be canceled automatically as of the effective date of such expiration, revocation, or termination."

"It was the unanimous opinion of the committee that this resolution be adopted and Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that Resolution No. 12 be adopted, was carried.

RESOLUTION NO. 20
Surgical Technicians

(By the Academy of Medicine of Cleveland)

"The Committee was in unanimous agreement with the resolution but suggests a slight change in the wording of "the resolved". Therefore, we submit the following amended resolution:

AMENDED RESOLUTION NO. 20
Surgical Technicians

WHEREAS, The problem of staffing operating room theaters with adequately trained technical assistants is becoming increasingly difficult each year, and

WHEREAS, The need for paramedical personnel is widely recognized, and

WHEREAS, Qualified institutions are developing satisfactory courses of instructions to train surgical technicians; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association endorse the training and use of such personnel in surgical units, and request the cooperation of the AMA and the American College of Surgeons in establishing requirements for such programs leading to qualification.

"Mr. President, I move the adoption of Resolution No. 20 as amended."

By official action, the motion to accept the recommendation of the committee, namely, that Amended Resolution No. 20 be adopted, was carried.

SUBSTITUTE RESOLUTION NO. 7 (1967)
Group Malpractice Coverage

"Substitute Resolution No. 7 and the report as made by the Ohio State Medical Association Council on March 31, 1968 were thoroughly discussed. It is the recommendation of this Committee that the House of Delegates authorize The Council of the



Mrs. J. Paul Sauvageot, Akron, 1967-1968 President of the Woman's Auxiliary to the OSMA, presents the Auxiliary report to the House of Delegates.



Dr. Stanley D. Simon, President of the host Cincinnati Academy of Medicine, officially opened the 1968 session of the OSMA House of Delegates and welcomed physicians and visitors to Cincinnati.



Dr. Bradley M. Harris, President of the Michigan State Medical Society, was among distinguished guests from neighboring states who brought greetings to the Ohio House of Delegates.

Ohio State Medical Association to conduct a poll of its members on group malpractice insurance and to proceed with indicated action resulting from this poll and Mr. President, I so move."

By official action, the motion to accept the recommendation of the committee, namely, that the House of Delegates authorize The Council of the Ohio State Medical Association to conduct a poll of its members on group malpractice insurance and to proceed with the indicated action resulting from this poll, was carried. **(See page 819 for text of resolution.)**

RESOLUTION NO. 24

Pollution of Lake Erie

(By the Fourth Councilor District)

"After studying this emergency resolution and considering the facts presented in the open hearings, rewording seemed wise. Therefore, we present a substitute resolution as follows:

SUBSTITUTE RESOLUTION NO. 24

Pollution of Lake Erie

WHEREAS, Present plans for dredging the Rouge River will result in further pollution of Lake Erie; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association protest this plan and any other advocated projects that will result in further pollution of Lake Erie, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association initiate and aid in plans for preventing and correcting pollution of Ohio lakes and streams.

"Mr. President, I move the adoption of Substitute Resolution No. 24."

By official action, the motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 24 be adopted, was carried.

RESOLUTION NO. 25

Wilbur J. Cohen and the U. S. Department of Health, Education, and Welfare

(By the Columbus Academy of Medicine)

"After thorough discussion in open hearings and further considerations in closed sessions, the committee recommends a substitute resolution as follows:

SUBSTITUTE RESOLUTION NO. 25

Wilbur J. Cohen and the U. S. Department of Health, Education, and Welfare

WHEREAS, The appointment of Wilbur J. Cohen, as Secretary of Health, Education, and Welfare, has been confirmed by the Senate of the United States without open hearing, and

WHEREAS, This appointment is an example of the disregard of the advice of the medical profession as documented by previous objections of The Council of the Ohio State Medical Association to Mr. Cohen's appointment, and

WHEREAS, The private practicing physicians are the best qualified group in matters pertaining to health services, THEREFORE, BE IT



Mrs. Karl F. Ritter, Lima, President of the Woman's Auxiliary to the AMA, addresses the OSMA House of Delegates, where she was an honored guest.



Distinguished guest of the Association was Dr. Edward R. Annis, Miami, Florida, Past President of the American Medical Association, who spoke briefly before the House of Delegates. Later in a program feature, he discussed Medicare and how the medical profession is faring under the program.

RESOLVED, That the Ohio State Medical Association request the Department of Health, Education, and Welfare to solicit and follow the advice and counsel of those practicing physicians designated by their state and local medical societies, in formulating future plans and programs, and to modify existing programs, in order to provide the best quality health care to the people of the United States; and BE IT FURTHER

RESOLVED, That the Ohio delegation to the American Medical Association be instructed to introduce at the AMA 1968 Annual Convention a similar resolution for consideration by the AMA House of Delegates.

"Mr. President, I move the adoption of Substitute Resolution No. 25."

The House amended the second Whereas paragraph of the substitute resolution to add after the word "appointment" the words "and the confirmation." Subsequent to this amendment, by official action, the motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 25 be adopted, was carried.

"Mr. President, I move the adoption of the Report of Resolutions Committee No. 3 as a whole, as amended.

"The chairman would like to express deep appreciation to the committee members who gave so generously of their time and wisdom. The chairman would also like to express appreciation for the efficient and generous help from the secretarial staff of the headquarters office.

"The members of the Committee are: Thomas E. Fox, Warren County; Maurice M. Kane, Darke County; Walter A. Daniel, Seneca County; P. A. Overstreet, Lucas County; William F. Boukalik, Cuyahoga County; G. E. DeCicco, Mahoning County; Carl A. Lincke, Carroll County; J. H. Kennedy, Licking County; Chester H. Allen, Scioto County; Charles W. Pavey, Franklin County; James T. Stephens, Lorain County, Chairman."

By official action, the report of Resolutions Committee No. 3, as a whole, as amended, was adopted.

Election of President-Elect

Dr. Howard called for nominations for the office of President-Elect. Dr. George N. Bates, Lucas County, placed in nomination the name of Dr. Robert N. Smith, Toledo, Councilor of the Fourth District. The nomination was seconded by Dr. Nicholas G. DePiero, Cuyahoga County, representing the Fifth District, and by Dr. Richard L. Fulton, Franklin County, Councilor of the Tenth District. There being no further nominations, **Dr. Smith was unanimously elected by a rising vote and was declared elected President-Elect.** Dr. and Mrs. Robert N. Smith were then introduced to the House of Delegates.

Election of Councilors

Dr. Jack Schreiber, Mahoning County, as chairman, presented the report of the Nominating Committee. The report was as follows:

First District

As Councilor of the First District to succeed himself, the committee placed in nomination Dr. Paul N. Ivins, Hamilton. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Ivins was declared re-elected Councilor of the First District for a term of two years, 1968-1969 and 1969-1970.**

Third District

As Councilor of the Third District to succeed Dr. Frederick T. Merchant, Marion, who was not a candidate for re-election, the committee placed in nomination the name of Dr. Dwight L. Becker, Lima. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Becker was declared elected Councilor of the Third District for a term of two years, 1968-1969 and 1969-1970.**

Fourth District

As Councilor of the Fourth District to serve out the unexpired term of Dr. Robert N. Smith, Toledo, who was elected President-Elect, the committee placed in nomination the name of Dr. George N. Bates, Toledo. There being no further nominations, by official action the nominations were closed and **Dr. Bates was declared elected Councilor of the Fourth District for a term of one year—1968-1969.**

Fifth District

As Councilor of the Fifth District to succeed himself, the committee placed in nomination Dr. P. John Robechek, Cleveland. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Robechek was declared re-elected Councilor of the Fifth District for a term of two years, 1968-1969 and 1969-1970.**

Seventh District

As Councilor of the Seventh District to succeed himself, the committee placed in nomination Dr. Sanford Press, Steubenville. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Press was declared re-elected Councilor of the Seventh District for a term of two years, 1968-1969 and 1969-1970.**



Guest Speaker Edward R. Annis drew an audience estimated at more than 700 persons for his talk entitled, "Medicare Plus Two Years — How Is the Medical Profession Faring?"

Eighth District

As Councilor of the Eighth District to complete the unexpired term of Dr. James A. Quinn, Jr., Newark, who resigned to establish a practice in Tulsa, Oklahoma, the committee placed in nomination the name of Dr. William M. Wells, Newark, who had been appointed by The Council to serve in Dr. Quinn's place until the 1968 meeting of the House of Delegates. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Wells was declared elected Councilor of the Eighth District for a term of one year, 1968-1969.**

Ninth District

As Councilor of the Ninth District to succeed himself, the committee placed in nomination Dr. Oscar W. Clarke, Gallipolis. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Clarke was declared re-elected Councilor of the Ninth District for a term of two years, 1968-1969 and 1969-1970.**

Eleventh District

As Councilor of the Eleventh District to succeed himself, the committee placed in nomination Dr. William R. Schultz, Wooster. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Schultz was declared re-elected Councilor of the Eleventh District for a term of two years, 1968-1969 and 1969-1970.**

AMA Delegates

The Nominating Committee then placed in nomination the following for the office of delegate to the American Medical Association for a term of two years beginning January 1, 1969: Drs. T. L. Light, Dayton; Carl A. Lincke, Carrollton; George W. Petznick, Cleveland; and Robert E. Tschantz, Canton. Since there were four delegate openings available and since there were no further nominations from the floor, by official action the nominations were closed and the **following were elected as delegates to the American Medical Association for a term of two years, beginning January 1, 1969: Drs. Light, Lincke, Petznick and Tschantz.**

AMA Alternate Delegates

For alternate delegates to the American Medical Association for a term of two years beginning January 1, 1969, the Nominating Committee placed in nomination the names of Drs. Kenneth D. Arn, Dayton, Henry A. Crawford, Cleveland; Harry K. Hines, Cincinnati; Robert S. Martin, Zanesville; and Robert E. Howard, Cincinnati. Inasmuch as five candidates

were nominated and four openings were available and since there were no further nominations from the floor, a written ballot was conducted and as a result of the ballot the following **were declared elected for a term of two years as alternate delegates to the American Medical Association, starting January 1, 1969: Drs. Crawford, Hines, Martin, and Howard.**

Inaugural Ceremony

Dr. Lawrence C. Meredith, Elyria, Immediate Past President of the Association, invited Mrs. Howard to the rostrum and presented Dr. and Mrs. Howard an engraved silver tray as the Association's token of appreciation for his year of service as President of the Ohio State Medical Association. Also, a special certificate of honor was presented to Dr. Howard for his services to the Association.

Dr. Meredith then continued the ceremony inaugurating Dr. T. L. Light, Dayton, as President of the Ohio State Medical Association. (Dr. Light's inaugural message appears on pages 850-851). Dr. Light presented to Dr. Howard the Past President's insignia.

Committees Named

Dr. Light made the following committee appointments which **were officially approved by the House of Delegates:**

Committee on Education — Dr. Thomas E. Rardin, Columbus, reappointed chairman for the ensuing year; Dr. John G. Sholl, Cleveland, appointed for a term of five years, 1968-1973; Dr. Edward L. Doermann, Toledo, appointed for a term of one year, 1968-1969, to fill the unexpired term of Dr. Thomas S. Brownell, Akron, who moved to Florida.

Judicial and Professional Relations Committee — Dr. Homer A. Anderson, Columbus, reappointed chairman for the ensuing year; Dr. Charles E. O'Brien, Dayton, appointed for a term of five years, 1968-1973.

Committee on Public Relations and Economics — Dr. Robert E. Howard, Cincinnati, appointed for a term of five years, 1968-1973, and appointed chairman for the ensuing year.

Committee on Scientific Work — Dr. Robert E. Zipf, Dayton, appointed chairman for the ensuing year; Dr. Isador Miller, Urbana, reappointed for a term of five years, 1968-1973; Dr. Samuel A. Marable, Columbus, appointed for a term of five years, 1968-1973.

The House of Delegates then adjourned sine die.

Attest: HART. F. PAGE
Executive Secretary

Roll Call of House of Delegates
1968 Annual Meeting

County	Delegate	First Session	Second Session
	FIRST DISTRICT		
ADAMS	Juan Young	Present	Present
BROWN	John R. Donohoo	Present	
	Andrew J. Pasquale		Present
BUTLER	Robert P. Johnson	Present	Present
CLERMONT	Carl A. Minning	Present	Present
CLINTON	Edmond K. Yantes		Present
HAMILTON	Frank P. Cleveland	Present	Present
	William C. Ahlering		Present
	Joseph G. Crotty	Present	Present
	William R. Culbertson	Present	Present
	Harry K. Hines	Present	
	Daniel V. Jones	Present	Present
	Carl W. Koehler	Present	
	Elmer R. Maurer	Present	Present
	Arthur W. Nadler	Present	Present
	Clyde S. Roof	Present	
	Eli Rubenstein	Present	Present
	Charles A. Sebastian	Present	Present
	Stanley D. Simon	Present	Present
	Albert E. Thielen	Present	Present
	Robert M. Woolford		Present
HIGHLAND	Clifford G. Foor	Present	Present
WARREN	Thomas E. Fox	Present	Present
	SECOND DISTRICT		
CHAMPAIGN	Isador Miller	Present	Present
CLARK	Henry Diederichs	Present	Present
	John W. Rechsteiner	Present	Present
DARKE	Maurice M. Kane	Present	Present
GREENE	Roger C. Henderson	Present	Present
MIAMI	Jerry L. Hammon	Present	Present
	John R. Brown	Present	
MONTGOMERY	Robert A. Bruce	Present	Present
	William G. Cassel	Present	Present
	William M. Porter	Present	Present
	Peter A. Granson		Present
	Franklin L. Shively, Jr.	Present	Present
	James G. Tye	Present	Present
PREBLE	Chester J. Brian	Present	Present
SHELBY	William Schroer	Present	Present
	THIRD DISTRICT		
ALLEN	Dwight L. Becker	Present	Present
	Fred P. Berlin	Present	Present
AUGLAIZE	Charles D. Stienecker	Present	Present
CRAWFORD	Horace B. Newhard		
HANCOCK	John C. Smithson	Present	Present
HARDIN	Clarence L. Johnson	Present	Present
LOGAN	Charles A. Browning	Present	Present
MARION	William H. Whitehead	Present	Present
MERCER	James J. Otis	Present	Present
SENECA	Walter A. Daniel	Present	Present
VAN WERT	H. C. Smith		
WYANDOT	Donald P. Smith		
	FOURTH DISTRICT		
DEFIANCE	Charles E. Jaeckle	Present	Present
FULTON	William J. Neal	Present	Present
HENRY	Thomas F. Moriarty	Present	Present

County	Delegate	First Session	Second Session
LUCAS	George N. Bates	Present	Present
	George T. Booth	Present	Present
	Edmond F. Glow	Present	Present
	Frederick P. Osgood	Present	Present
	P. A. Overstreet		Present
	Frank F. A. Rawling	Present	Present
	John B. Sawyer	Present	
OTTAWA	Cyrus R. Wood	Present	Present
PAULDING	D. E. Farling	Present	
PUTNAM	Milo B. Rice	Present	
SANDUSKY	Robert A. Borden	Present	
	Anthony C. Rini		Present
WILLIAMS	J. E. Moats		Present
WOOD	Clarence B. Nyce	Present	Present
	FIFTH DISTRICT		
ASHTABULA	Shepard A. Burroughs	Present	
CUYAHOGA	Joseph C. Avellone	Present	Present
	William F. Boukalik	Present	Present
	John H. Budd	Present	Present
	Christopher A. Colombi	Present	Present
	E. Peter Coppedge	Present	
	Henry A. Crawford		Present
	Nicholas G. DePiero		Present
	Eduard Eichner		Present
	Eugene A. Ferreri	Present	
	David Fishman	Present	Present
	John J. Gaughan	Present	Present
	John J. Grady	Present	Present
	Robert E. Hermann	Present	
	Clarence L. Huggins		Present
	Herbert H. Johnson	Present	
	Roscoe J. Kennedy	Present	Present
	Vincent T. LaMaida		Present
	M. H. Lambright	Present	Present
	Lawrence J. McCormack	Present	Present
	Paul A. Mielcarek	Present	Present
	George W. Petznick	Present	Present
	J. K. Potter		Present
	John H. Sanders	Present	Present
	A. B. Schneider, Jr.	Present	Present
	Leo H. Simoson	Present	
	Frederick T. Suppes	Present	
	William V. Trowbridge	Present	Present
	Jess R. Young		Present
GEAUGA	Alton W. Behm	Present	Present
LAKE	Robert A. Irvin		Present
	W. J. Pignolet		Present
	SIXTH DISTRICT		
COLUMBIANA	William S. Banfield	Present	Present
MAHONING	G. E. DeCicco	Present	Present
	Joseph V. Newsome	Present	Present
	Jack Schreiber	Present	Present
PORTAGE	David Palmstrom	Present	
STARK	Andreas S. Ahbel	Present	Present
	E. E. Grable	Present	Present
	Mark G. Herbst	Present	Present
	Maurice F. Lieber	Present	Present
SUMMIT	Richard H. Champion	Present	
	Douglas Evans	Present	Present
	Thomas W. Jackson	Present	Present
	D. W. Mathias		Present
	L. H. Walker	Present	Present
	Marshall R. Werner	Present	Present
	Robert E. Yeakley	Present	Present
TRUMBULL	Steven A. Pollis	Present	Present
	Rex K. Whiteman	Present	Present
	SEVENTH DISTRICT		
BELMONT	E. V. Arbaugh, Jr.	Present	Present
CARROLL	Carl A. Lincke	Present	
	Glenn C. Dowell		Present
COSHOCTON	Norman L. Wright	Present	Present
HARRISON	Janis Trupovnieks	Present	Present
JEFFERSON	Crist G. Strovilas	Present	
	Paul Mastros		Present
MONROE	Byron Gillespie		
TUSCARAWAS	R. E. Rinderknecht	Present	Present

County	Delegate	First Session	Second Session
	EIGHTH DISTRICT		
ATHENS	Philip Kinnard		
FAIRFIELD	Chester P. Swett	Present	
	Jack L. Kraker		Present
GUERNSEY	Robert A. Ringer	Present	Present
LICKING	J. H. Kennedy	Present	Present
MORGAN	Henry Bachman		Present
MUSKINGUM	Carl E. Spragg	Present	Present
NOBLE	Edward G. Ditch		
PERRY	Ralph Herendeen, Jr.		
WASHINGTON	Kenneth E. Bennett	Present	Present
	NINTH DISTRICT		
GALLIA	Thomas W. Morgan	Present	Present
HOCKING	Jan S. Matthews		
JACKSON	W. T. Washam		Present
LAWRENCE	A. Justin Payne	Present	
MEIGS	Roger P. Daniels	Present	Present
PIKE	Albert M. Shrader	Present	
SCIOTO	Chester H. Allen		Present
VINTON	Richard E. Bullock		
	TENTH DISTRICT		
DELAWARE	A. R. Callander	Present	Present
FAYETTE	Robert A. Heiny		
FRANKLIN	Michael A. Anthony	Present	Present
	Joseph A. Bonta	Present	Present
	James C. Good	Present	Present
	Robert A. Heilman		Present
	Tom F. Lewis	Present	Present
	Charles W. Pavey	Present	Present
	H. William Porterfield	Present	Present
	William P. Smith, Jr.	Present	Present
	Donald W. Traphagen	Present	Present
KNOX	James C. McLarnan	Present	Present
MADISON	Sol Maggied	Present	Present
MORROW	Joseph P. Ingmire	Present	Present
PICKAWAY	Jasper M. Hedges	Present	Present
ROSS	Lewis W. Coppel	Present	Present
UNION	Paul R. Zaugg	Present	
	ELEVENTH DISTRICT		
ASHLAND	Myrle D. Shilling	Present	Present
ERIE	Emil J. Meckstroth	Present	
	Robert D. Gillette		Present
HOLMES	Owen F. Patterson		Present
HURON	William R. Graham	Present	Present
LORAIN	Charles Butrey	Present	Present
	Ben V. Myers	Present	Present
	James T. Stephens	Present	Present
MEDINA	Richard W. Avery	Present	Present
RICHLAND	Wendell M. Bell	Present	Present
	Carl M. Quick	Present	Present
WAYNE	Albert B. Huff	Present	Present
	OFFICERS		
President	Robert E. Howard	Present	Present
President-Elect	Theodore L. Light	Present	Present
Past President	Lawrence C. Meredith	Present	Present
Treasurer	James L. Henry	Present	Present
	COUNCILORS		
FIRST	Paul N. Ivins	Present	Present
SECOND	George J. Schroer	Present	Present
THIRD	Frederick T. Merchant	Present	Present
FOURTH	Robert N. Smith	Present	Present
FIFTH	P. John Robechek	Present	Present
SIXTH	Edwin R. Westbrook	Present	Present
SEVENTH	Sanford Press	Present	Present
EIGHTH	William M. Wells	Present	Present
NINTH	Oscar W. Clarke	Present	Present
TENTH	Richard L. Fulton	Present	Present
ELEVENTH	William R. Schultz	Present	Present
	Totals	151	153

EXPERIMENTS PERILOUS

By ROBERT E. HOWARD, M.D., Cincinnati

YOUR PRESIDENT recorded the action of the Ohio State Medical Association during the first six months, in the January issue of *The Ohio State Medical Journal*, so I will not repeat.

Since then the Corson Report of the Federal Conference on Medical Costs and the Gorham Report have appeared, as well as the Health, Education, and Welfare's Report on Promoting the Group Practice of Medicine, also the Report of the President's Commission on Health Manpower and the National Conference on Private Health Insurance are being studied and discussed. The Barr Advisory Committee on Hospital Effectiveness and the Kissick and Jones Commission on Costs of Health Care Facilities shows the attempt of HEW to control Hospitals.

I strongly urge in these changing times, that you send for all seven of these reports and read them carefully, because Wilbur Cohen's 44-page testimony before the Congressional Committee on Health Care costs and the future of medicine are based on these reports and conferences. Wilbur Cohen denies that he wishes to socialize medicine and facilities, since he believes this means ownership, he only wishes, through his powers and through compulsory, comprehensive health service, to control medicine and hospitals. I ask you, do you want this to happen?

The Social Security Amendments of 1967 seek to alter the pattern of medical care and reimbursement through incentive guidelines, experiments for Medicare, Medicaid, and Maternal and Child Health Programs as authorized and proposed by the Secretary of HEW.

It is sickening that I must report to this House of Delegates that four physicians — one the vice-chairman of the AMA's Council on Legislative Activities; one a past president of the AMA and currently a member of the Council on Legislative Activities, also a past president of the American Academy of General Practice; and one who is currently president of the Association of American Medical Colleges — that these four men wrote letters praising and endorsing the appointment of Wilbur J. Cohen to the high office of Secretary of the United States Department of Health, Education, and Welfare.

For documentation, I refer you to the *Congressional Record*, May 3, 1968, Pages S-4912 to 4915.

Changes Are Occurring

Changes in health care patterns already are occurring. With Wilbur Cohen displacing Dr. John Gardner as HEW Secretary, the socialist move is advancing much faster than anyone anticipated. Organized labor, hospitals, Blue Cross, National Blue Shield, and voluntary health agencies all are participating in this rapid change.

The health of the American People is medicine's most important concern. The individual responsibility of the doctor to the patient — (and the patient to the doctor) — must not be sacrificed in any new plans being offered.

As long as the doctor directly bills the patient and refuses assignments or a fixed fee for service, then nothing will disturb the doctor-patient relationship. Third party contracts must be with the patient — not the doctor — and the patient must have the responsibility of payment to the doctor. This is possible under Medicare so far, and the Congress promised us that the doctor's usual, customary, and reasonable fee would be paid under the Medicare law.

It is important to note that Title 19 was federally bankrupt April 1. On that date, the federal government halted federal matching funds to the state, awaiting Congressional passage of a huge deficiency appropriation bill.

Most doctors who are knowledgeable of the new voluntary experiment under the 1967 Social Security Amendments (Public Law 90-174), realize that this allows:

(1) HEW to fix or control fees for services, and

(2) HEW eventually to socialize medicine through prepaid capitation, closed-panel group practice that is consumer controlled.

The decision to carry out the experiment was based on the conclusions of the President's Commission on Health Manpower, the National Conference on Medical Costs, the Conference on Private Insurance, and the HEW Conference on Group Practice. These conferences concluded that some health insurance plans encourage over-utilization of expensive hospi-

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Presented before the House of Delegates of the Ohio State Medical Association on May 13, 1968, in Cincinnati. For the report of the Committee on the President's Address, in the official proceedings of the House of Delegates, see page 821 of this issue.

tals and health professionals and are not given economic incentives to discourage provision of unnecessary care.

One Man's Voice

Our next AMA President, Dr. Dwight Wilbur, was the only medical organizational member of President Johnson's Health Manpower Commission and had difficulty in changing the social pattern of the commission. The recent California plan of capitation for Title 19 patients in four counties is the result of the strategy to continue to force needy Americans into cut-rate health care, not in the interest of quality care for those citizens, but in the interest of trying to promote socialism and lower cost.

The health professions, as anticipated in California, are expected, first by threat and then by force, to reduce their normal fees and charges to subsidize another government failure and socialist miscalculation just as we are doing in Ohio under Title 19. It is time to show Wilbur Cohen, Phil Lee, Robert Ball, and liberal politicians and administrators that doctors — not bureaucrats — practice medicine. We will not permit our medical system to deteriorate as happened in England, Sweden, and other such countries by allowing HEW to implement major and illegal regulatory changes not in the law.

Doctors have the opportunity for nonparticipation — or call it individual responsibility to the patient — to counteract government interference. In four provinces in Canada, the doctors have taken this action and the Medicare law has been delayed for further negotiations and determination of priorities.

Your President was invited to speak to the Ohio AFL-CIO leaders. He repeatedly had to defend doctors from labor and SSA abuses.

I also attended, with other doctors from Ohio, the miserable AMA Conference on the Poor in December, 1967, that featured Shriver and the Chicago demonstrators on National TV coverage, without adequate AMA reaction, and the controversial AMA Congress on Socioeconomics of Group Practice in March, 1968, featuring the Socialist Medical Economist, Dr. Fuch's advocating compulsory Universal Health Service along with the various prepaid group plans. The tilting of AMA congresses for the opposition must stop. I have yet to see a government or HEW Commission or Conference favorably structured with adequate private practitioner representation.

Due to the legislation generated during the 89th Congress, the Cities Demonstrative Act, the Comprehensive Areawide Health Planning Act, and the Economic Opportunity Act, the federal definition of group practice as written by the U. S. Department of HEW Secretary Wilbur Cohen, is clearly outlined as a prepaid, closed-panel group controlled by consumer with salaried physicians and absolutely no free choice of physician or fee for service.

Private Practice Will Survive

The loose use of the term "group practice" by the social planners as their goal for health care is a semantic steal which many physicians, including myself, deeply resent.

I believe that the private practice of medicine, be it solo practice, single specialty or multi-specialty group, as predominates in these United States, can and will continue unless the socialists in government and labor completely socialize medicine.

You will note that I refer to these interests as socialists. You will note that I refer to their goals as socialized medicine. Members of this House of Delegates, they are socialists and their goal is socialized medicine. You may call it government medicine, liberal medicine, or consumer medicine, but, if you call a spade a spade, it is socialized medicine.

HEW and labor are using our tax dollars to promote this type of practice;

With reports from HEW involving false comparisons of health statistics of the United States with certain socialist or communist nations;

With the distorted facts of the report of the national conference on health care costs;

With the preconceived and misleading reports of the national health manpower commission;

With membership on such commissions and study groups limited only to those persons who agree, in advance, not to submit a minority report;

With all these efforts aimed at destroying or dividing the American Medical Association and the private practice of medicine, I am convinced that it is time for organized medicine and private practice to speak up, loudly, clearly, and repeatedly.

I therefore charge this House of Delegates, the officers, The Council, and the members of OSMA to oppose actively the socialization of medicine, *both as citizens and as doctors.*

Critics of our stand may say, "The same old tirade." I say to these critics that we physicians battle disease throughout our entire professional lives. Socialized medicine is a political disease, and we will battle it with the same intensity that we battle physical and mental diseases.

We have no alternative unless we want to be slaves of bureaucrats with federalized and centralized controls based on compulsory comprehensive universal health service without free choice of physician or fee for service.

INAUGURAL MESSAGE

By THEODORE L. LIGHT, M.D., Dayton

ON EVERY CONCEIVABLE OCCASION I wish to ask — Who are we? What are we? I do this because I believe it important that we, the Medical Profession, re-examine ourselves and restate our purpose in life.

What is man? Man is the highest order of life on this earth. Man is an individual living animal. An amoeba is the simplest and lowest animal. An amoeba is also an individual living animal. Amoebas recreate themselves repeatedly by splitting into two separate entities, each living individual lives; competing for an existence in the same drop of pond water. Amoebas thoughtlessly grab for themselves cherished food regardless of the needs of others. Amoebas excrete waste without thought of others, befouling their environment to the point of destroying all. Amoebas live thoughtlessly, by pure instinct and uncontrolled urge, recreating into such mass numbers that they fill their environment to overflowing, causing the destruction of all. Is man reflected here?

Let us look at man again. Man is a system of specialized organs integrating their functions for the best life and function of the whole animal. If individual cells in organized functioning groups fail to maintain a proper balance and fail to recreate adequately, as in senility, overcreate, as in cancer; become incapacitated by hostile environment, as in acute disease; or fail to properly maintain their purposeful functions, as in degenerative disease, death may follow.

Each human is a cell in a functioning organ and purpose in society. He must recreate himself in that purpose, and in ability, to function for the good of all. Each of us has duties and purposes that must be adequately carried on by enough members of that group, or all society will die by senility, cancer, acute disease, or degeneration.

Man's Unique Place

Some intelligence assigns and gives direction to groups of cells, at the proper time in the formation of the embryo, to change their nature for special function. Man, however, as a cell in the special organ of society, is not so assigned. Man has a free spirit, an intellect, and a will. Man assumes his place in society through the chance fitting together of variable factors in his inheritance and in his environment. Man is amenable to ideas and goals of other men and with their guidance and example chooses his place in the duties of society. In so choosing, he has a reasonable sense of joy and fulfillment in that place and duty. There can be an infinite variance in dull acceptance and joyful fulfillment in each of us.

Under the increasingly complex requirements of today's society, a certain amount of regimentation by those in high places of government, industry, the professions, the unions, and the social planners is quite likely. Regimentation is the easier way. It is only natural for those in high places to believe they are the only ones with adequate view of the total complex and thus the ones to dictate how man will react toward man.



In ceremonies before the House of Delegates, Past President Lawrence C. Meredith presided at the inauguration of Incoming President Theodore L. Light, and presented him with the gavel as a symbol of his high office.

The required assumption of a role in society, as designated by a dictator, only serves to cause conflict, even worse, mute acceptance. With increasing acceptance, society will not produce enough thinkers for its further need of innovation. Conflict, generated out of rejection of assigned role, can accumulate into riot and revolution.

Dr. Light was installed as President of the Ohio State Medical Association at the final session of the OSMA House of Delegates, Cincinnati, May 16, 1968. This article is the text of his message prepared as part of the presidential inauguration.

Man and Responsibility

Man has a free spirit, intellect, and will. These factors must lead him to rational conclusions about his place in society and cause him to set precept and example in the guidance of others to a desirable position in society.

Man must commit himself to the belief that each man must be responsible for his acts and his life, according to A. M. Pruitt, M. D., in "A Rift Between Friends in the War of Ideas," published by Rampart College, unless each individual is responsible and held responsible for his actions by his fellows, neither the individual nor his social group can ever achieve anything worthwhile. This responsibility includes teaching children responsibility; teaching them values; giving them a moral code by which they can determine and judge what is right and what is wrong. Teach them to respect their own lives and their own property and the lives and property of others. Teach them that they deserve only what they can earn, and that what they achieve can only be done through education, self-discipline, and the maximum development of their own ability. Discipline them in these matters so that they may achieve, as adults, the self-discipline which is imperative to any human if he is to become a responsible and self-respecting being. Teach them these things because these are the attributes from which arise all that is noble in man, and which give him what we call human dignity, incentive, understanding, and compassion. The need to have a majority of the members of society believing and acting within these concepts is the only way man will avoid regimentation and a degradation of God's gift of free spirit, intellect, and will.

The present trend of our social planners in Washington and elsewhere is based on the premise that 90 per cent of the citizens of this country are too stupid to manage their own affairs and provide for the needs of their useful lives and for the needs of their unproductive retirements. If this be true, then surely we should join them. If this be false, then the planned economy will remove responsibility and encourage the dull acceptance of regimentation.

The Professional Viewpoint

As committed beings with intellect, spirit, and will, trained and practicing as physicians, we know best about the interrelationships of man. We see men become dull animals in their adjustments that are forced upon them. We see family conflicts and social upheaval due to the rejection of their position when they see no better method of adjustment. We have demonstrated that the intelligent direction of persistent effort can overcome physical handicap. We know that physical work to the level of fatigue is therapeutic in anxiety tension reactions. We have seen faith and dominant will bring patients through crises that seemed to be insurmountable.

As concerned citizens who see the degradation of man resulting from the current social planning, there are things we must do!

We must lend our effort and understanding to the community to change welfare from a dole to a concerted effort in assistance to the underachievers that they may become useful citizens again. We must lend our effort and understanding to the educators and to the school systems of our community in order to greatly increase the education level of the deprived persons so that they become useful units in society. Society is ill if too great a segment of its body is nonfunctioning or functions in a destructive manner.

We must aid our community to avoid doing for people what they should best do for themselves. It is better to spend more time in leading your fellowman to his fullest development of self-responsibility than to take the short cut of taking over his life.

We must believe thoroughly in the doctrine of individual responsibility. We must practice that doctrine by explaining to each patient the areas of responsibility for the relief of illness, that belong to the physician and to the patient so that each coordinate his efforts to best advantage. That the patient be responsible to pay a just fee is an important part of his treatment and a commitment of faith.

We are citizens of our society and must take our part in the recreation and proper function of our chosen role. We must treasure God's gift of intellect, spirit, and will and always endeavor to enhance these gifts in all men.

We, the physicians of this country, can be and should be the citizens most concerned with the planning of the interactions of man to man, because therein lies the greatest single source of good health for all.

Annual Meeting Attendance . . .

Figures Show How This Year's Excellent Attendance Compares with Tabulations on Other Annual Meetings

REGISTRATION FIGURES for the 1968 OSMA Annual Meeting in Cincinnati, May 13-17, show an excellent attendance, both in number of members, and in the total number of persons present. Overall registration was 3465, with the following breakdown: Members of the Association, 1300, guest physicians, 230, medical students, 35; Woman's Auxiliary, nurses, dentists, technicians, and miscellaneous guests, 1287; scientific and technical exhibitors, 613.

Following are registration figures for members of the Association by counties and a comparison of Annual Meeting attendance figures from 1919 through 1968.:

County	Total Membership Dec. 31, 1967	Total Membership May 9, 1968	Ann. Meet. Registration
Adams	10	10	5
Allen	129	129	17
Ashland	26	25	5
Ashtabula	61	56	4
Athens	40	41	1
Auglaize	19	17	3
Belmont	53	54	3
Brown	17	16	6
Butler	185	180	41
Carroll	10	10	2
Champaign	17	16	1
Clark	131	130	23
Clermont	23	20	9
Clinton	19	20	7
Columbiana	73	68	8
Coshocton	23	22	4
Crawford	40	39	3
Cuyahoga	2311	2204	90
Darke	25	26	5
Defiance	24	25	5
Delaware	26	26	5
Erie	63	62	6
Fairfield	51	49	10
Fayette	15	15	3
Franklin	951	861	130
Fulton	17	16	2
Gallia	35	31	5
Geauga	27	28	3
Greene	54	57	12
Guernsey	26	24	2
Hamilton	1262	1236	449
Hancock	46	45	6
Hardin	27	26	2
Harrison	7	7	2
Henry	12	13	1
Highland	17	17	3
Hocking	9	9	1
Holmes	10	10	2
Huron	29	29	5
Jackson	15	15	2
Jefferson	66	69	8
Knox	36	34	4
Lake	104	110	5
Lawrence	22	23	4
Licking	68	65	8
Logan	15	15	3
Lorain	204	200	16
Lucas	632	572	39
Madison	13	13	4
Mahoning	349	341	14
Marion	67	61	5
Medina	56	50	12
Meigs	6	6	2
Mercer	18	17	2
Miami	67	64	8
Monroe	3	4	
Montgomery	577	572	94
Morgan	3	3	1
Morrow	8	8	3
Muskingum	75	75	10
Noble	2	2	
Ottawa	22	21	2
Paulding	8	8	2
Perry	6	7	
Pickaway	20	21	2
Pike	9	9	2
Portage	58	58	4
Preble	7	7	2
Putnam	11	10	3
Richland	120	119	17
Ross	42	38	13
Sandusky	48	45	3
Scioto	65	64	10
Seneca	43	41	5
Shelby	24	24	2
Stark	355	339	24
Summit	572	566	29
Trumbull	132	134	9
Tuscarawas	53	53	9
Union	16	16	2
Van Wert	20	20	5
Vinton	1	1	
Warren	15	14	3
Washington	31	31	8
Wayne	61	64	3
Williams	17	17	1
Wood	38	37	5
Wyandot	11	11	
TOTAL	10,131	9,763	1,300

ANNUAL MEETING REGISTRATION FOR 1919-1968 INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.; Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1818
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with AMA						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			411	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	185	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182
1960	Cleveland	1642	489	48	1026	447	3652
1961	Cincinnati	1256	231	24	751	301	2563
1962	Columbus	1304	265	343	736	371	3019
1963	Cleveland	1502	336	19	893	441	3191
1964	Columbus	1428	332	297	1002	376	3435
1965	Columbus	1330	275	335	968	394	3302
1966	Cleveland	1484	309	22	865	355	3035
1967	Columbus	1327	286	394	1178	405	3590
1968	Cincinnati	1300	230	35	1287	613	3465

Ohio Press Reflects OSMA Annual Meeting

. . . examples of hundreds of articles clipped from Ohio newspapers . . .

Area Teams Top Medical Unit Awards

Cleveland institutions won awards by The Plain Dealer when the exhibit was shown at the Chicago meeting of the American ... of Obstetrics and ... went to Dr. John D. Blair and Miss Carolyn A. Leonard of Case Western Reserve University for their exhibit ... chromosome analysis in medical practice.



Bagwell, of 7412 Shenandoah drive, Florence, co... X-ray display of rheumatoid arthritis of the hand ... Veterans Administration Hospital display ... State Medical Assn. convention.

rgymen Take Stand on 'Pill';
e Arouses Prai... Criticism

on 'The Pill,'" a ... clergyman has ... eeting of the Ohio ... dical Assn.

ave the right to ... parenthood," he ...

atholic priest said, ... of the pill for con... is immoral and ... e law of God."

philosophy fa... control and the ...stion is when the ... be prescribed, a ... during a panel ... on the last day ... week-long OSMA ...nvention.

Hospital, said th... changed sexual ... "but so did the ... drive-in movie ... time."

"The pill n... be one of the ... coveries of ... said.

THE REV... dorn said ... of the Cath... use of the ... ceptive is ...

Father ... St. Mary... sor, said ... all Cath... teachin... Fath...

Heart Ambulance Sought for Area

By FRASER KENT
Staff Medical Writer

CINCINNATI—An emergency "coronary ambulance" may be in the books for the Greater Cleveland ... gates to the Ohio State Heart Association's ... ing reported here yesterday.

It would be available for taking a ... heart attack to the nearest hospital, pro... care and supervision on the way. In effect ... the hospital's coronary unit to the patient.

DR. RAY ...

Impersonal Attitude Of Many Dr... Believed Aiding Medical Quack...

Cardiologist Urges Emphasizing 'Milk ... Human Kindness'

...gion in time of trouble and used ... a prayer cloth each night for a ... period of six months ... each morning to find ... breast cancer had dis... Finally, in a terrifying ... sought conventional ... only after she ... herself that her ... lack of faith ... for the failure.

"Other Seek... "There ... miracle" ... who d... gion ... so...

...phasized by ...sion on "me... the meeting of ... Medical Associ...

...eakers, Dr. W... t. Lubbock, T... nd author o... t Quackery: ...ime physic... ffer than ...anding.

...ledo Man Named President-Elect ... Ohio State Medical Association

...NCINNATI—(AP) Dr. Rob... tering the funds, grants and proj... S. Smith of Toledo has been ...eets as an economy move.

...ed president-elect of the ... State Medical Association. ...ing here.

...election came as Dr. Theo... L. Light of Dayton was in... ...d as president for the com... ...ear. Dr. Light succeeds Dr. ...rt E. Howard of Cincinnati.

...Smith is a graduate of the ...d States Military Academy, ...Massachusetts Institute of ...logy and the University of ...ska College of Medicine.

...udy of the feasibility of ...dating under a single ... the many state health ...

...plied with an elect... ...monitor the heart beat... ...ack; a mechanical ca... ...t the stopped heart, a ...nd intravenous medicat...

...SIMILAR unit has been ...gland, where it has be... ...many patients who wo... ...to the hospital. ...how lose many heart p... ...ergency room, or even ...eiving treatment." Dr... ...uld sharply ...

...ed by a medical ... those who have ...

Dr. Light Heads State Medical Associati...

Theodore L. Light, of ... (2670 Salem Avenue) Dayton, ... was installed as President of ... the Ohio State Medical Asso... ciation in Cincinnati May 16 ... by the Association's ... Delegates. ... Robert ... ti.

Dr. Ra... Gallatin ... elected pre... 10,000-mem... physicians an... Light in 1969. ... Dr. Light is ... the Univer...

...arch Continues
Cancer-Virus Link

Sabin's Efforts So Far Have Met ...h Failure; Heredity Factor Pursue...

By RAY BRUNER
Blade Science Editor

...NATI—Can the inhabitants of Saba Island in the Carib... ...d an isolated community of Samaritans in Israel pu... ...rt Sabin with the material he needs for finding ... ...ses cause human cancer?

...an, they might help open a way toward ...ital disease.

...famous virologist ... of the University of ...dical Center, spe... ...ecting the live virus ... has been used to ...re than 400 million ...world's inhabitants. ...Closely related to ...ding achievement ...years of effort to ... involved in human ...

MDs Hear Report On Pseudo-Gou...

By FRASER KENT
Staff Medical Writer

...INCINNATI—Gout may ... of the oldest afflictio... ...wn to man, but physicia... ...e long been puzzled ... ...e few patients to did n... ...pond to standard trea... ...nt. Now there is eviden... ...se few patients who did n... ...pseudo-gout" that deman... ...fferent kind of therapy. ... mistake in diagnosis cou... ...n damaging changes ... of the kidney and oth...

Roland W. Moskowit... ...t professor of me... Case Western Reser... ...ity, has now fou... ...ttacks of arthritis th... ...e gout. Also, a chron... ...nation and thicken... joint that resembl... ...toid arthritis may ... to "pseudo-gout."

REPORTED his fin... ...sterday to the Oh... ...edical Association ...al meeting here.

Doctors Set ... Convention

...r. Roger C. Henderson of ... ...a will be the Gue... Co... ...gate and Dr. Paul C. Ve... ...of Fairborn, will be the el... ...te at the annual ... ...e Ohio State Medical ...

Smoker Told How Cancer Develops

...At heavy smokers in ... time develop abnormal ... growth that can suddenly ... burst into lung cancer, Dr. ... E. Culer Hammond, a vice ... president of the American ...

Dr. Dilworth OSMA Delegate

Dr. Robert Dilworth, Mont... ...delegate ...with Dr. ...lternate, ...al As... ...l meet... 13-17. ...sicians ...arly 135 ...in their ...

State Needs Problem

Will Study Single ... Ohio Health Age...

...the Ohio State Medical As... ...has voted to study ... health pro... planning and ha... der the Office ... Opportunity, ... to the Aged, ... to Disabled, ... children, ...

Benefits Community

OSMA Focuses on the Galion Plan

...A Marion physician, who ... ...heads a unique health ... ...tions of the panel and ... into a job that will not over... ...Trouble Clinic, which ...

Annual Meeting Roundup . . .

Good Attendance. Excellent Program. Spacious Exhibits. All Add Up to Another Successful OSMA Annual Meeting

THE QUEEN CITY provided an excellent setting for the 1968 OSMA Anuual Meeting, with events centered in the new Cincinnati Exposition Center and the Netherland Hilton Hotel. With more than 130 speakers, panelists, and other participants on the scientific program alone, members found a wide choice of meetings to attend and occasions during which they could chat with their colleagues. Breakfasts, luncheons, social house, and informal get-togethers added much to the week's events and activities and to the success of the statewide meeting.

Th reader will find in this issue official proceedings of the House of Delegates, biographical data on the new officers and information about other members of The Council, the President's Address, the Inaugural Message of the Incoming President, attendance record, report of the Woman's Auxiliary, etc.

It would be out of the question to report accurately all events and happenings of the Annual Meeting. The few miscellaneous items in the following paragraphs are presented in an attempt to reflect the spirit of the meeting, and to relate some of the events that transpired. Photographs distributed throughout these reports portray only a few highlights and sidelights of the week's activities.

From Near and Far

Inviting guest speakers from the four corners of the land was literally true in regard to the Cincinnati meeting. On the program were speakers from Miami, Florida, and Seattle, Washington; from Los Angeles, California, and Boston, Massachusetts — some 20 out-of-state guest speakers in all. Two were from overseas — Dr. Alan J. Mooney, from Dublin, Ireland; and Dr. Joachim Kohn, from London, England.

News Media Coverage

The press, radio, and TV were well represented at the Annual Meeting; advance releases were sent out to news media; and additional releases were forwarded during the meeting. See special montage in this issue showing newspaper clippings of articles dealing with the OSMA Annual Meeting.



Just named President-Elect of the Association by the House of Delegates, Dr. Robert N. Smith addresses the House and accepts the responsibility and honor bestowed upon him.

AMA-ERF Checks

Presentation of checks from the American Medical Association Education and Research Foundation was a function of the House of Delegates program. Dr. Robert S. Martin, Zanesville, Ohio chairman of AMA-ERF, made the presentations to the following persons representing their respective schools:

Dr. Clifford G. Grulee, Jr., Dean of the University of Cincinnati College of Medicine;

Dr. Richard L. Meiling, Dean, Ohio State University College of Medicine;

Dr. David Fishman, Case Western Reserve University School of Medicine; and

Dr. Frank F. A. Rawling, Medical College of Ohio at Toledo.

Guests from Liaison Groups

The Annual Meeting reflects in part the spirit of liaison which the Association maintains with other statewide organizations interested in the medical-health fields. Among invited guests were presidents or other officers from the Ohio Dental Association,



At the speakers' table during The Council's dinner meeting are Dr. and Mrs. James L. Henry, Dr. and Mrs. Theodore L. Light, and Mrs. Robert E. Howard.

Ohio Hospital Association, Ohio State Pharmaceutical Association, Ohio Veterinary Medical Association, Ohio Academy of General Practice, and other groups. The Ohio State Society of Medical Assistants was represented, as was the Student American Medical Association in Ohio.

House of Delegates

Members who attended sessions of the House of Delegates saw a truly representative government in action. Every County Medical Society in the state is entitled to representation in the House. Larger Societies have representation in proportion to membership.

Policy of the Association is established primarily through resolutions presented before the House of Delegates and voted upon there. All resolutions are openly discussed before Reference Committees where Association members and invited guests may appear and be heard. The Reference Committee's report is made to the House of Delegates where further discussion by delegates may be heard before a vote is taken.

Woman's Auxiliary

In addition to activities of their own meeting, members of the Woman's Auxiliary contributed in many ways to the success of the OSMA Annual Meeting. Many of the ladies were active in the planning stages and during the meeting to assure that facilities were provided and events went according to schedule.



Dr. Frank H. Mayfield, chairman of the Ohio Medical Political Action Committee, presided at the OMPAC luncheon meeting which drew an excellent attendance of more than 300 persons.

At the Gaslight Party the ladies, many in costume, added much to the comfort and entertainment of members and guests.

For details on the Woman's Auxiliary annual meeting, see special article in this issue.

Past Presidents Honored

The traditional dinner meeting of The Council honoring Past Presidents of the Association with its "Ladies' Night" atmosphere was held on Tuesday evening of the Annual Meeting week. See photograph elsewhere in this issue of Past Presidents who attended the event.

An interesting sidelight of the evening's events was presentation to Dr. and Mrs. Robert E. Howard of a sketch painted by Dr. James S. Klumpp, Past President of the West Virginia Medical Association. Long an "ambassador of good will" to Ohio, Dr. Klumpp was unable to be present because of family illness.



Dr. and Mrs. Robert E. Howard display a silver engraved tray, presented in behalf of the Association as a token of appreciation for the President's year of dedicated service in office. Dr. Lawrence C. Meredith, right, Past President, made the presentation.

The Host Society

As president of the host Academy of Medicine of Cincinnati, Dr. Stanley D. Simon officially opened the House of Delegates and welcomed members and guests to the Queen City. The host society's activities were far-reaching; committees worked long and hard in the planning stages and during the Annual Meeting week.

Committee members and some of the Academy staff were present not only at hotel functions but during scientific sessions in the auditorium. They went all out to follow through on detail planning, bridged the communications gap on many emergency calls, and in general contributed much to the needs and comforts of members and guests.

Wood Carving Presented



This beautiful wood carving of the Seal of the Ohio State Medical Association is the work of Past President Lawrence C. Meredith who is shown presenting it before the House of Delegates. It now hangs in the reception area of the OSMA Headquarters Office in Columbus over an engraved plate with the notation: "Carved and Presented by Lawrence C. Meredith, M. D., President 1966-1967, Ohio State Medical Association."

The Seal, adopted in its present form at the direction of the OSMA House of Delegates, shows the Staff of Aesculapius (traditional symbol of medicine) superimposed over the Great Seal of Ohio. The date 1835 marks creation of a "voluntary" statewide medical organization in Ohio, and notes a milestone in the rich tradition under which physicians have united "to promote the science and art of medicine, and the protection of the public health."



The Honorable Robert Taft, Jr., Congressman of the Ohio First District, speaks before the luncheon meeting sponsored by the Ohio Medical Political Action Committee during the OSMA Annual Meeting, where more than 300 persons were present.

. . . and a good time was had by all

. . . at the GASLIGHT PARTY













Outstanding Scientific Exhibits Recognized at Annual Meeting

AMONG 41 Scientific Exhibits shown at the 1968 OSMA Annual Meeting in Cincinnati, a judging committee selected several as outstanding. The Scientific Exhibits were part of perhaps the largest display of exhibits shown at an annual meeting. The spacious floor of the new Cincinnati-Exposition Center also included 26 Health Education Exhibits and 108 Technical Exhibits.

Annual meeting planners have authorized a monetary award as well as permanent, mounted plaques and certificates for certain outstanding exhibits. The judging committee also designated one exhibit for a Special Award and a number of additional exhibits for Honorable Mention. Following is a list of award winning exhibits and those selected for special honors.

Gold Award in Original Investigation: The exhibit, "A Perinatal Unit — A New Concept in Obstetrical Research in Maternal and Infant Care," depicting a service being developed by the Cleveland Metropolitan General Hospital. Exhibit sponsors were: Jacques Roux, M. D., Peter Adam, M. D., Maximino Alcancia, M. D., Reinhart Billiar, M. D., Frank Critchfield, M. D., August Hensons, B. S., M. Jassani, M. D., Katherine King, M. D., Margaret Knappenberger, B. S., Rosemary Lemr, R. N., T. J. Lin, M. D., M. Lindheimer, M. D., Brian Little, M. D., Michael R. Neuman, Ph. D., R. Schwartz, M. D., A. Sweet, M. D., and Peter Weston, M. D.

Gold Award in Teaching: The exhibit, "Surgical Management of Bilateral Air Cysts," sponsored by the following team from the Huron Road Hospital, Cleveland — John Storer, M. D., M. Paul Thomas, M. D., and A. Grierson, M. D.

Silver Award in Original Investigation: The exhibit, "Dose Reduction and Radiopharmaceutical Dosimetry in Pediatric Nuclear Medicine," sponsored by a team from the Radioisotope Laboratory, University of Cincinnati College of Medicine and Nuclear Medicine Unit, National Center for Radiological Health, Cincinnati. The team consisted of James G. Kereiakes, Ph. D., Henry N. Wellman, M. D., Eugene L. Saenger, M. D., Vince Sodd, Ph. D., Gustave K. Bahr, Ph. D., Ben I. Friedman, M. D., James Mack, M. D., and Byron Branson, M. S.

Silver Award in Teaching: The exhibit, "Anterior Segment Eye Disease," sponsored by Ira A. Abrahamson, Jr., M. D., and Ira A. Abrahamson, Sr., M. D., Department of Ophthalmology, University of Cincinnati College of Medicine.

Bronze Award in Original Investigation: The exhibit, "Mitral and Aortic Valve Replacement with a Caged Lens Prosthesis," sponsored by Frederick S. Cross, M. D., Motoichi Akao, M. D., and Richard D. Jones, Ph. D., St. Luke's Hospital, Cleveland.

Series on Outstanding Exhibits To Be Published in Journal

Because of the obvious educational value of the Scientific Exhibits, and for the further purpose of bringing to its readers additional information on the material presented, *The Journal* will publish a series of special articles on the several exhibits judged as outstanding. This tribute is in keeping with a policy established by the Committee on Scientific Work, and approved by The Council.

Watch for the coming issues of *The Journal* and illustrated features about exhibits listed in this article. Through this means, *The Journal* not only will salute the outstanding exhibits, but will attempt to acknowledge the many hours of research and preparation all of the sponsors have put behind their presentations.

Bronze Award in Teaching: The exhibit, "Leg Ulcers — Differential Diagnosis and Treatment," sponsored by Henry H. Roenigk, Jr., M. D., and Jess R. Young, M. D., of the Cleveland Clinic Foundation, Cleveland.

Special Award in Original Investigation: The exhibit, "Chromosome Analysis in Medical Practice," sponsored by John D. Blair, M. D., and Carolyn A. Leonard, B. A., Case Western Reserve University



Dr. Alan J. Mooney, Dublin, Ireland, discusses diabetic retinopathy during a program sponsored by the OSMA Section on Ophthalmology and the Ohio Ophthalmological Society.



Dr. Herman K. Hellerstein, Cleveland, was principal speaker for the program sponsored jointly by the Ohio State Heart Association.

School of Medicine and Cleveland Metropolitan General Hospital, Cleveland.

Honorable Mention in Original Investigation:

The exhibit, "Physiologic Voiding Test in Children," sponsored by the following team from Akron General Hospital — Walter A. Keitzer, M. D., Birendra Tandon, M. D., James Allen, M. D., Edward Bernreuter, M. D., and Mark Harrold, M. D.

The Exhibit, "The Laser in Cancer Research," sponsored by the following team associated with the Laser Laboratory, Children's Hospital Research Foundation and Medical Center, University of Cincinnati — Leon Goldman, M. D., J. R. Rockwell, Jr., M. Sc., Edmond Ritter, Ph. D., V. E. Siler, M. D., Donald Blaney, M. D., James Fidler, M. D., Robert Meyer, Robert Otten, and K. W. Kitzmiller, M. D.

The exhibit, "Blood Cytology in Cancer," sponsored by the following team from Ohio State University Hospital Department of Pathology, Columbus — Thomas D. Stevenson, M. D., Joan C. Mattson, M. D., and Emmerich von Haam, M. D.

Honorable Mention in Teaching:

The exhibit, "Teaching Urinalysis," sponsored by Arthur T. Evans, M. D., and Robert Helmling, M. D., Department of Urology, University of Cincinnati College of Medicine.

The exhibit, "Surgical Aspects of Intersex," sponsored by William R. Richardson, M. D., and Lester W. Martin, M. D., Cincinnati Children's Hospital and Department of Surgery, University of Cincinnati College of Medicine.

The exhibit, "Post Phlebitic Disease," sponsored by E. A. Husni, M. D., Huron Road Hospital, East Cleveland.



Dr. Albert B. Sabin, Children's Hospital Research Foundation, Cincinnati, discoverer of the oral polio vaccine which bears his name, was one of the principal speakers at the annual conference sponsored by the Ohio Division of the American Cancer Society. He discussed the search for possible roles of viruses in human cancer.

Honolulu, Hawaii is the setting for the first joint meeting of the International College of Surgeon's two Western Hemisphere Federations, from September 28-October 3, 1968. This year for the first time the South American Federation will join the nations from the North American, Central American, and Caribbean Federations who will be celebrating their 33rd Annual Congress. Among panelists for a discussion of "Circulatory Assist Devices" is Dr. John H. Kennedy, of Cleveland.

Woman's Auxiliary Report...

Review of Year's Activities in Ohio Presented Before OSMA House of Delegates in Cincinnati

By MRS. PAUL SAUVAGEOT, Akron

1967-1968 President, Woman's Auxiliary to the Ohio State Medical Association

SO THAT my thank-you will not seem like an afterthought at the end of my report, I wish to express the sincere appreciation of the Auxiliary Board of Directors and especially my personal gratitude for the cooperation we have received from Dr. Howard and from Dr. Merchant, chairman of our Advisory Committee. These doctors have answered letters promptly and have given us guidance in every way when we have asked. Mr. Page and Mr. Campbell from the OSMA office have been most helpful, too.

This year has not been marked by a myriad of startling new projects and programs — nor was it meant to be. This has been a year of evaluation — a year when auxiliaries throughout the state were asked to take critical looks at our programs — to see if we are serving our medical societies, our academies of medicine — and our communities to the best of our abilities — and then to discontinue, revamp or go ahead with these programs accordingly.

Along with this evaluation, auxiliaries and individual members were asked to be aware of our responsibilities public-relationswise. Need for this was brought dramatically to our attention when an informal survey was made in various Ohio cities a little more than a year ago. Some 70 persons in no way connected with the medical profession were asked: "When someone mentions 'doctors' wives,' just what does this mean to you?" (I must say this was before Dr. Slaughter came out with his book by that title and before he and I started our somewhat spirited correspondence — which you may have heard about). However, consensuses of the persons interviewed in the survey seemed to be that of a leading industrialist who remarked: "Doctors' wives? Why, to me they mean mink stoles, Cadillacs, and darn good bridge players." Now don't for a minute think I am against any of these things but the point is that not one person mentioned service despite the thousands of hours given by auxilians everywhere. You may ask: "Isn't it enough that we give service whether anyone knows it or not?" I don't think so, if we are to get rid of the mink stole and Cadillac label which many of us deplore. So we made concerted efforts this year to tell our story of service and that is why — to you, the people we try most to please — I am summarizing what we have accomplished since May 1967. Here, then, is our story:

Community Services

Let us consider first community service. Without exception established major projects reported in previous years have continued to grow. I'd like to tell you about them. Lucas County initiated a most successful meals on wheels — only to find that the name must be changed for such projects throughout the country. Meals on wheels some years ago was registered as the trademark of a commercial concern — so now a tentative new name has been selected — Meals a la Car.

Forty Ohio counties assumed responsibility for at least one community project ranging from help with geriatric patients and senior citizens programs to working with retarded children of pre-school age — 11 conducted immunization programs, six helped with disease detection, ten sponsored health education programs including family life education, three sponsored rehabilitation projects, six conducted hearing and visual tests, one sponsored a community program on self-defense for women. The community service chairman gathered statistics throughout the state, and in computer fashion picked three typical doctors' wives — each to be known as Mrs. MD Ohio. These names will be announced. (See report of Auxiliary Annual Meeting.)

Our international health chairman reports that we shipped more than eight tons of sample drugs to world medical relief, as well as equipment ranging from dental instruments to a sewing machine; 20 counties participated in Project Hope; and nine counties have planned for, entertained and helped families of foreign doctors.

AMA-ERF

Forty counties have contributed $35,000 to AMA-ERF — A $6,000 increase over the amount contributed just a year ago. However, we will not know un-

til the end of May how the entire year's total will compare with last year's.

Virtually all auxiliaries have shown increased interest in legislation with more counties following through on former doctor-wife voter registration, or undertaking such registration for the first time. We are pushing OMPAC membership for auxilians. We feel sure our efforts, coupled with yours, should show results in November.

I wish time permitted to tell of the expanded work of auxiliaries in the field of safety and of mental health. Recruitment for health careers has taken a new and broader look as we move into the comprehensive health manpower area — and we are giving special attention to future doctors' clubs. During the year scholarships for students going into health careers amounted to $17,700.

Emphasis at Local Level

County auxiliaries are the backbone of the state auxiliary — yes, and of national, too. All state and national can do is offer guidelines. Each county must do what it believes best locally. One president wrote in her annual report: "Ours is not a super-organized auxiliary. We are a small, rather informal group sensitive to the people around us — for we know them well."

Another wrote: "Our auxiliary does not want to be a money making machine. We were determined during the year to get to know one another better and become aware of what we — as auxiliary members — can do best to help our husbands."

Still another: "Often the auxiliary becomes less and less important as many members rush around and become involved in a million and one activities. I believe an effort should be made to counteract this attitude at all levels if the medical community hopes to work together to be a force for what is right and best for our communities and for our country.

With thinking such as expressed by these doctors' wives and with the achievements I have reported we feel we are making impacts on our communities. We hope we are making an impact on you, too.

In some counties we have no auxiliaries — you don't even want us — and perhaps this is our fault. Maybe you are gun-shy because once upon a time some doctors' wives might have been too aggressive. Auxiliaries can be assets to you and to our communities only where you guide us, inspire us, encourage us, want us. Good auxiliary leaders put auxiliary goals and interests above personal ambitions — Frank Slaughter notwithstanding. The woman who says she eats and sleeps auxiliary is the auxiliary's worst enemy — for our philosophies and programs must fit neatly into the schemes of medical societies, our communities — and most of all — our families.

Each auxiliary must be what you, our doctors, want us to be — nothing more — nothing less. So you can readily see that our success, our achievements, and our effectiveness depend very, very much on you.

A contribution of $10,000 has been made by Winthrop Laboratories, a division of Sterling Drug Inc., to the American Medical Association's Education and Research Foundation.

The forty-seventh annual convention of the National Easter Seal Society for Crippled Children and Adults will be held in Boston, November 13-16, 1968. Sessions will be held in the Sheraton-Boston Hotel.



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Auxiliary Annual Meeting Report . . .

Convention Held in Conjunction with OSMA Annual Meeting; Results of Election; Summary of Events; Honors Bestowed

By MRS. ROBERT E. PUMPHREY, Chairman, Publicity Committee
3055 Big Hill Road, Dayton 45419

A PLEASURABLE RESPONSIBILITY came to this writer at the close of the 28th annual convention of the Woman's Auxiliary to the Ohio State Medical Association, with its beautiful Americana theme. After the outgoing president, Mrs. Paul Sauvageot had turned over the gavel to the incoming president, Mrs. Malachi Sloan, and after Mrs. S. L. Meltzer had transferred to me the publicity chairman's brief case, I began to feel a deep sense of accountability resting on my shoulders. With the office also goes the responsibility of bringing to the Ohio State Medical Association monthly a correct report of Auxiliary activities in as interesting and concise a manner as possible.

I extend my deep gratitude to Mrs. Sloan, president, to Mrs. Meltzer, president-elect, and to members of The Journal staff, for their helpfulness at the starting post. Suggestions from any and all members of the Ohio State Medical Association and the Auxiliary are always welcome. County Publicity Chairmen! PLEASE keep us advised of your special activities!

Mrs. Meltzer has reported the Auxiliary news in this publication for the past four years in such a clever and competent way that I realize my task of living up to her fine example will not be a small one. I can only promise that I will do my very best and that I do thoroughly respect and look forward to my assignment with eager anticipation.

"Let's Tell Our Story"

The twenty-eighth Annual convention of the Woman's Auxiliary to the Ohio State Medical Association, with Mrs. Harry Fry, of Cincinnati and Hamilton County, serving as chairman and Mrs. Carl Schilling cochairman, lived up to its title, "Let's Tell Our Story" in two exciting days with a kickoff Ragtime Riverboat Cruise on the Johnston party boat. The evening was clear and beautiful and a wonderful time was had by all!

The Americana theme was carried out during the entire convention in beautiful and original ways — programs were red, white, and blue, red, white, and blue drums decorated tables, hostesses wore red, white, and blue, Mrs. Paul Sauvageot, 1967-1968 president WA-OSMA, wore for the opening session a navy blue sheath dress, piped in red and white. The first official session began promptly on May 15 at 11:30 A.M. with Mrs. Sauvageot presiding. The invocation was given by Mrs. Herbert Van Epps, Tuscarawas County Past State President.

The Doctor's Belles of Summit County, directed by Mrs. Wendell King, gave a superb choral program that included such musical hits as "Hello Ladies" (takeoff from Hello Dolly); "Spring is Here"; "Daisy, Daisy"; and "After the Ball Is Over."

Dressed in Alice blue cotton sheath dresses, wearing printed scarves in gay colors, the ladies made a striking appearance and were enthusiastically received. Their performance ended with a solemn and dramatic "Let There Be Peace on Earth — and let it begin with me."

Mrs. Carl Goll, Jefferson County, second vice-president, led the giving of the Pledge of Allegiance and the Auxiliary Pledge of Loyalty. A cordial welcome was extended by Mrs. Joseph Ghory, president of Hamilton County, with a grateful response by Mrs. L. V. Phillips, president, Summit County.

"Eleven Months Filled with Fabulous Firsts"

These were the opening words of the address given by Mrs. Karl F. Ritter, president of the Woman's Auxiliary to the American Medical Association, following her introduction by Mrs. John D. Albertson, president of Allen County. Mrs. Ritter said that she has been "stimulated by achievement and saddened by apathy." She gave much credit to those who had helped her so much. She stated that there are many changes and problems in the world today and that the whole approach to health care is under discussion. "Let our critics not distort facts in the effort to improve health care, and not equate our shortcomings with failure." She quoted statistics on the large amounts of money that have been given by the Medi-



This chorus from Summit County entertained at the Americana Luncheon of the Woman's Auxiliary, honoring Mrs. Karl F. Ritter, Ohio's President of the Woman's Auxiliary to the AMA, and Dr. Edward R. Annis, AMA Past President.

cal Association and its Auxiliaries for scholarships and to those entering the field of health and education.

Proud of Leadership from Ohio

In a brief and poignant welcome to the members of the convention, 1967-1968 OSMA President Robert E. Howard said that he was proud of the leadership from Ohio and stressed the fact that communication means so much to all concerned. The speaker was introduced by Mrs. Sauvageot.

President's Summation

Following Dr. Howard's address came the introduction of out-of-state guests by Mrs. Herman Nimitz, Hamilton County, Past State President; introduction of convention chairmen; drawing for Early Bird prizes, conducted by Mrs. Emil Barrows, Hamilton County; minutes of the 1967 convention by WA-OSMA Mrs. James W. Loney Recording Secretary, Cuyahoga County; treasurer's report by Mrs. R. L. Wiessinger, Allen County; report of Resolutions Committee, first reading, by Mrs. Carl Sedacca of Clermont County; Mrs. Sauvageot's summation of her period in office as president; and thank yous to all concerned; report of nominating committee by Mrs. James N. Wychgel, Cuyahoga County; amendments to Bylaws by Mrs. John Dickie, Lucas County; and instructions for voting by Mrs. Rudolph Cook, parliamentarian, Cuyahoga County.

Americana Luncheon Honors Mrs. Ritter, Dr. Annis

Mrs. Sauvageot presided over the colorful Americana Luncheon honoring Mrs. Ritter, and Dr. Edward Annis, Past President of the AMA. The invocation was given by the Very Reverend John C. Staunton, of Cincinnati. The honored guests delivered greetings and spoke briefly. The Summit County Doctors' Belles gave an impressive rendition of the Battle Hymn of the Republic.

Mrs. Harry L. Fry, chairman of the convention, is to be commended for her excellent directions for walking to the Netherland Hilton from the Terrace Hilton, which she gave so humorously and expertly, using military gestures (or flagman's signals) to describe the right and left turns. With her repeated well-defined instructions everyone should have been able to enjoy a short recess between events and still arrive at the Americana luncheon on time.

Triplets for "Mrs. M. D. Ohio"

The following names were announced by Mrs. E. L. Doerman, Lucas County, first vice-president, as those who had been selected for the title of "Mrs. M. D. Ohio": Mrs. Leon H. Moore, Sandusky

County; Mrs. Wendell Zaring, Hardin County; and Mrs. William Grannis, Allen County. A salute to these women who were selected for their outstanding work in their communities and for being all around special people.

Arts and Crafts Exhibits Outstanding

Much credit goes to these women who engineered the arts and crafts exhibits and the Auxiliary exhibit: Mrs. Arden Steele; Mrs. Charles Simmons; Mrs. Williams Jennings, and Mrs. H. Hudson Baumes. Many members contributed their talents in the form of paintings, needlework, and art craft.

Auxiliary members deeply appreciated the invitation to attend the General Session OSMA in the Cincinnati Exposition Center, with Dr. Edward Annis, M. D., Past President of the AMA, speaking on "Medicare Plus Two Years," and the OMPAC luncheon at which the Honorable Robert A. Taft, Jr. was noted speaker. Dr. Jack Lewis, M. D., Montgomery County, vice-chairman of OMPAC gave a report.

"Scenes and Schemes of the County Auxiliaries and AMPAC-OMPAC Session" was presided over by Mrs. Paul Jones, of Zanesville, Credits Awards chairman. This year slides were a feature. They were very entertaining and pointed up the special activities of the counties. A highlight of the afternoon was guest speaker Mrs. Frank Gastineau, AMPAC Board Member, introduced by Mrs. A. H. Kyriakides, Legislative chairman.

Gaslight Party a Great Success

The Gaslight Party was a great success, featuring young and attractive ladies from the WA-SAMA Cincinnati chapter as hostesses, bringing to life costumes and songs from the "Gay Nineties."

Chef Gregory Shares His Secrets

Thursday morning convention members and guests were launched into a delightful and entertaining morning with fresh strawberries, an entre, and Chef Gregory's piece de resistance — all in honor of county presidents; past state presidents and out-of-state guests. Did you know that room temperature is a basic European rule for the fresh eggs that go into an omelet; that salting them will make them stick to the skillet; that sweet butter is best to use, and that a dash of lemon will lighten and add a certain something? All this and more, too, Chef Gregory, of the Terrace Hilton, shared with his attentive audience as he tossed omelets, lit the brandy on flambes and added strawberries, almonds, and marmalade for finishing touches. He is working on a book called "The Other Side of the Table." Decorations at the head table for the breakfast were lovely and different — brass kettle, filled with geraniums; crock adorned with wooden spatulas; basket of eggs; white ceramic chickens, big and small.

Incoming OSMA President, Dr. Theodore Light addressed the second business session of the WA-OSMA with a sincere evaluation of what goals we are striving to attain — urged that we all work together to attain them. He gave many vital statistics on health facts as they exist today.

Mrs. Sloan Installed

In her address following her installation Mrs. Sloan said she feels that we are all deeply concerned for the people around the world who cannot afford to have medical care — future and present programs designed by National WA-AMA are far-reaching in scope. She urges innovation and implication — communication spelled out in working together. She stressed that by 1975 Health Care will be Number 1 in the nation.

Mrs. Sloan was presented with a bouquet of red carnations and received a standing ovation. Immediately following the installation a reception was held in honor of the new president in the Terrace Hilton,



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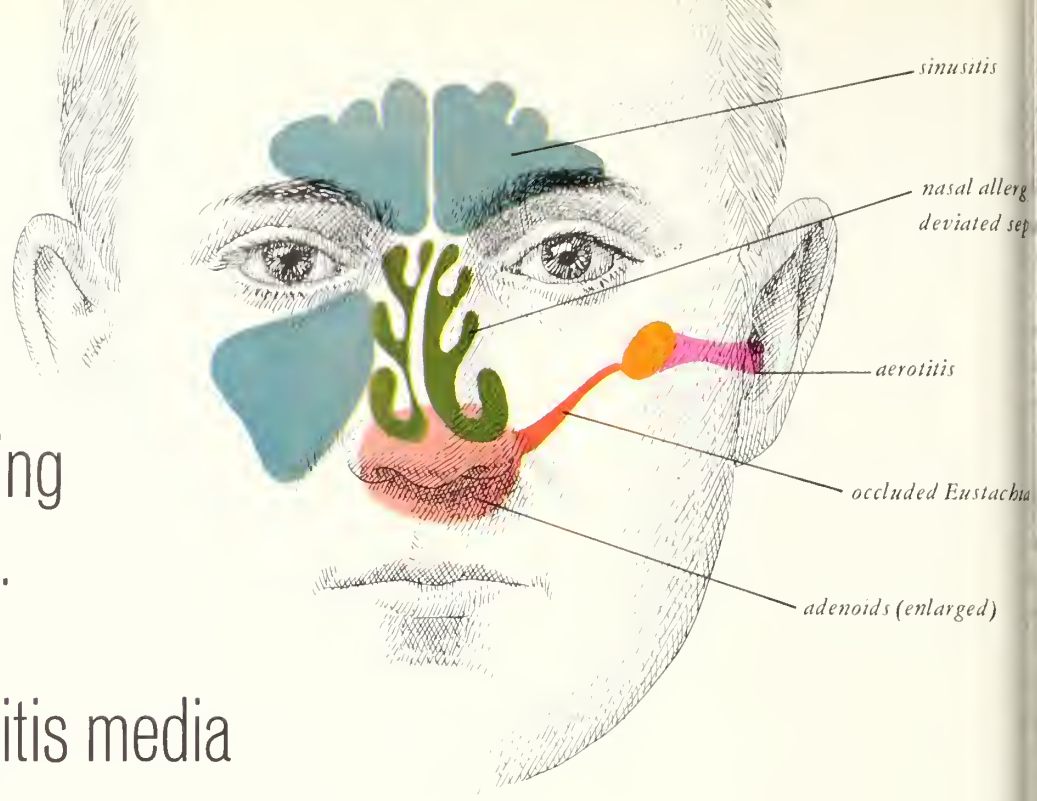
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this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thi glue-like fluid causes immobility of both the ov and round window. Both conditions return to no mal when the fluid is removed, but they make t interpretation of screening audiograms very difficul

There is no single cause for serous otitis. One fa tor always present is blockage of the eustachia tube, but this alone is not enough to produce flui There must also be an inflammatory reaction. Bloc age of the eustachian tube may be caused by mar conditions. In children the most common cause enlarged adenoids. In the summer the next mo common cause is allergy. Upper respiratory infe tions or influenza are common causes in the winte Nasal allergy, acute and chronic sinusitis, nasal se tal deformity and cleft palate can all cause eust chian tube obstruction. Some children may have congenitally small eustachian tube, but fortunatel they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often serous otitis. One must always rule this out in ar adult who later in life develops repeated or persis ing serous otitis. Causes sometimes overlooked a nasogastric tubes after surgery, simple obesity an cardiorenal disease, which may produce congestio in the mucosal lining of the eustachian tube. In r cent years we have been seeing a new cause—acut otitis media, where the patient is adequately treate with antibiotics but where drainage has not bee

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

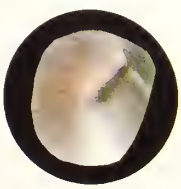
If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

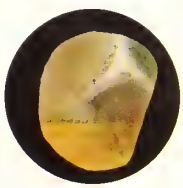
The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



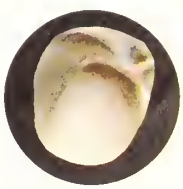
Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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chaired by Mrs. Delatus Brown, of Montgomery County.

Elected Delegates to the 1968 National Convention are as follows: Mrs. S. L. Meltzer; Mrs. H. F. Van Epps; Mrs. H. L. Fry; Mrs. C. M. Frye; Mrs. R. L. Wiessinger; Mrs. P. A. Jones; Mrs. Robert Tschantz; Mrs. E. L. Jung; Mrs. J. Rose; Mrs. C. H. Thompson; Mrs. Harry Hines; Mrs. John Young; Mrs. J. N. Wychgel; Mrs. William B. Mikita; Mrs. C. Columbi; Mrs. Paul Grove; and Mrs. Carl Lincke.

Mrs. Sauvageot asked those attending the convention to stand for a moment of silence and dedication in memory of Mrs. James E. Purdy, Canton; Mrs. W. W. H. Curtiss, Denison; and Mrs. J. L. Stevens, Mansfield, who died during the past year.

Following is a roster of officers, directors-at-large, and district officers:

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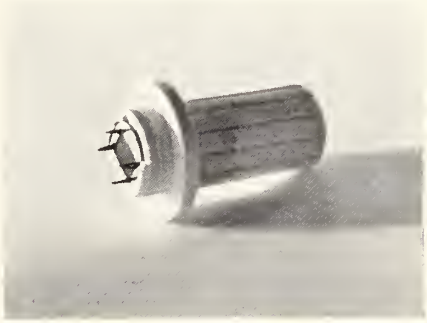
Mrs. R. H. Williamson (Ruth)
410 Wasta Ave., Huron 44839

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District 4	Mrs. Howard E. Smith (Carolinea) 2144 Fordway Dr., Toledo 43606
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District 6	Mrs. L. A. Loria (Eileen) Bristolville 44402
District 7	Mrs. Paul Hahn (Jo) 122 Moore Ave., N.W. New Philadelphia 44663
District 8	Mrs. Paul A. Jones (Caroline) 423 Coventry Circle, Zanesville 43701
District 9	Mrs. A. A. Melior (Illa) Rt. 1, Cook Rd., Lucasville 45648
District 10	Mrs. Ben Arnoff (Eileen) 5700 Olentangy River Rd., Worthington 43085
District 11	

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Editorial Staff Complimented

Mrs. H. W. Allison, Editor of the Auxiliary News, and her assistant editors, Mrs. Wendell Bucher and Mrs. Robert B. Hosier, and staff received much appreciation from presidents and past presidents for their outstanding contributions to WA-OSMA.

Proceedings of The Council...

Two Sessions Held in Connection with OSMA Annual Meeting In Cincinnati; Roster of OSMA Committee Members Approved

A SPECIAL MEETING of The Council of the Ohio State Medical Association was held May 15, 1968, at the Netherland Hilton Hotel, Cincinnati, during the 1968 Annual Meeting. All members of The Council were present. Others attending the meeting were: Dr. John H. Budd, Cleveland, Chairman, Ohio delegation to the AMA; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; and Messrs. Page and Edgar of the OSMA staff.

The Council convened in executive session. After the executive session The Council issued the following statement:

"The Council of the Ohio State Medical Association met in special session May 15, 1968, to consider a report of an interview with Dr. Theodore L. Light, published in the May 14 edition of the *Cincinnati Post-Times Star*.

"It was the unanimous opinion of the members of The Council that this published interview does not represent the policy and the philosophy of the Ohio State Medical Association, and Dr. Light has assured The Council that this interview as published does not accurately represent the opinions expressed by him to the reporter.

"The Ohio State Medical Association has a long and continuous record of encouraging and supporting the providing of high quality medical care to all needy citizens as well as to all citizens in every area of this State. This Association has always opposed any medical program, government or otherwise, which does not serve the best interests of all citizens.

"The Ohio State Medical Association does not endorse, and does not intend to endorse, any specific candidate for elective office; nor does this association engage in partisan politics. It does encourage individual physicians to fulfill their responsibility of citizenship by taking an active interest in good government."

Wilbur J. Cohen

The Council then reconvened in regular session with Dr. Budd, Mr. Stichter, and Messrs. Page and Edgar. Dr. Budd presented a statement approved by Ohio's AMA delegation which met May 14, 1968, in Cincinnati. Such statement had to do with the endorsement of Wilbur J. Cohen as secretary of the Department of Health, Education, and Welfare by certain physicians holding responsible appointments within the American Medical Association. It was voted that the statement be forwarded to the AMA Board of Trustees at the direction of and with the approval of the OSMA Council.

It was agreed that there be a briefing session at the next meeting of The Council on how to meet the press.

The meeting then adjourned.

Attest: HART F. PAGE,
Executive Secretary

MEETING OF MAY 17, 1968

A meeting of The Council of the Ohio State Medical Association was held in Dr. Light's suite, Netherland Hilton Hotel, Cincinnati, Friday, May 17, 1968, during the 1968 Annual Meeting of the Association. All members of The Council were present except Dr. James L. Henry, Treasurer, and Dr. William R. Schultz, Councilor of the Eleventh District. Others attending the meeting were: Dr. John H. Budd, Cleveland, Chairman, Ohio delegation to the AMA; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. David B. Weihaupt, Chicago, AMA Field Representative; and Messrs. Page, Edgar, Campbell, and Clinger of the OSMA staff.

Minutes Approved

The minutes of the meeting of The Council, held March 30-31, 1968, were approved by official action.

Adjustment of Dues

Dues for the year 1968 for a Cleveland physician were waived.

Committee Appointments Approved

By official action, The Council approved the appointments to special committees for 1968-1969, as presented by Dr. Light. (See this issue of *The Ohio State Medical Journal*, beginning on page 878, for the personnel of these committees.)

Staff Commended

The Council voted to commend the entire staff for the efficient operation of the 1968 Annual Meeting.

June AMA Meeting

Dr. Budd, Chairman of the Ohio delegation to the AMA, reviewed four resolutions which had been

approved by The Council and three resolutions adopted by the House of Delegates for submission to the annual meeting of the American Medical Association, San Francisco, in June.

Bank Credit Cards

The matter of the acceptance of bank credit cards in payment for medical services was brought before The Council. It was decided that the matter needs further study. The Executive Secretary was requested to obtain additional materials for The Council in advance of the next meeting.

Medical Assistants

A request from the Ohio Chapter of the American Association of Medical Assistants for funds to assist the chapter in the hosting of the national meeting of that organization in Columbus, Ohio, was presented by the chairman of the Advisory Committee to the Ohio State Society of Medical Assistants. The Council voted to allow up to $1,000 for this purpose, subject to the review of the Auditing and Appropriations Committee.

Ohio Medical Indemnity, Inc.

The Council voted that the chairman of the OMI Liaison Committee and chairman of the nominating committee be the Immediate Past President of the OSMA each year, and that the liaison committee consist of three Councilors of the OSMA, plus the Executive Secretary and the Secretary of the OSMA Committee on Insurance. This action was amended to the extent that for this year the liaison committee be increased by adding Dr. Tschantz to the committee.

Award Plaques

The staff was instructed to study the design and cost of a proposed plaque to honor AMA delegates and alternates, chairmen and members of standing committees, and chairmen of special committees at the termination of their services to the Association.

Dr. Light announced a "think" session of The Council and Dr. John Budd, chairman of the AMA delegation, at Wooster, Ohio, July 27, 1968.

The meeting then adjourned.

Attest: HART F. PAGE,
Executive Secretary

KEOGH PLAN AMENDED

Full Income-Tax Deduction for Self-Employed Professional Pensions this year.

The amended Keogh plan will allow a full deduction beginning in 1968 of the pension contribution for the Owner-Employer. This tax saving plan also allows you to invest in an income tax deferred plan.

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Ad Astra

Edward O. Bauer, M. D., Middletown; Miami Medical College, Cincinnati, 1909; aged 86; died May 13; member of the Ohio State Medical Association and the American Medical Association. Dr. Bauer was a native of Brown County. A physician and surgeon of long standing in Middletown, he moved there in 1911 and retired in 1953. Among community interests was his work in behalf of building and improving of Middletown Hospital. A veteran of World War I, he is survived by his widow, two sons, three brothers, and a sister. One son is Dr. John L. Bauer, also of Middletown.

Alfred Clinton Carr, M. D., Cleveland; University of Florida College of Medicine, 1961; aged 30; died May 20. Dr. Carr was undergoing residency training in obstetrics and gynecology at Cleveland Metropolitan General Hospital. He is survived by his widow, two children, his parents, a brother, and a sister.

Euthymides E. De Moss, M. D., Canton; Faculty of Medicine of the National University of Athens, Greece, 1911; aged 86; died January 25.

John Emmert Groff, M. D., Dayton; University of Cincinnati College of Medicine, 1933; aged 59; died May 10; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Dayton for some 26 years, Dr. Groff is survived by his widow, a daughter, two sons, three brothers, and three sisters.

Arthur Frederick Hagedorn, M. D., Cleveland; University of Cincinnati College of Medicine, 1918; aged 75; died May 17; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A practitioner of many years standing in Cleveland, Dr. Hagedorn was formerly physician for the Cleveland Boxing Commission and for the Amateur Boxing Trainers Association. He was a member of the Athletic Club and several Masonic bodies. Among survivors are his widow, a son, a daughter, and a sister.

James Mace Harkey, M. D., Canton; University of Arkansas School of Medicine, 1934; aged 59; died May 15; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A practitioner of long standing in Canton, Dr. Harkey was chief of pediatric services at Timken Mercy Hospital. He was a veteran of World War II, during which he served in the Army Medical Corps. A vestryman in the Episcopal Church, he is survived by his widow, a son, a daughter, two brothers and a sister.

Frederic N. Hayward, M. D., Toledo; Toledo Medical College, 1900; aged 94; died May 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Hayward practiced a total of 55 years in Toledo, retiring some 12 years ago. Among survivors are his widow, three sons, a stepson, and two daughters.

Sara E. Hewetson, M. D., Freeport, Illinois; Ohio Medical University, 1898; aged 98; died May 17. One of the few women graduated from medical school before the turn of the century, Dr. Hewetson formerly practiced in St. Clairsville, at one time in association with her father, the late Dr. Alexander Hewetson. A niece survives.

Norman C. Hochwalt, M. D., Dayton; Ohio State University College of Medicine, 1921; aged 71; died April 30; member of the Ohio State Medical Association, the American Medical Association, and the American College of Obstetrics and Gynecology. A practitioner in the Dayton area for about 45 years, Dr. Hochwalt retired in 1966. Among affiliations, he was a member of the Catholic Church and the Knights of Columbus. Survivors include his widow, a daughter, two sons, and two brothers.

Oliver P. Kimball, M. D., Lancaster, Pa.; Western Reserve University School of Medicine, 1918; aged 81; died May 7; former member of the Ohio State Medical Association; Fellow of the American College of Physicians. Dr. Kimball practiced from 1917 to 1955 in Cleveland where he was recognized as an authority in treatment of goiter and epilepsy, and made world tours in behalf of goiter prevention and treatment. While in Cleveland he commuted to Detroit where he was medical director of a school for epileptic children. In Pennsylvania, he was medical director for a division of the Sperry Rand Corporation. Survivors include his widow, two sons, and three sisters.

David Lee Kinsey, M. D., Columbus; Ohio State University College of Medicine, 1955; aged 38; died May 19; recent member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery and of

the American Board of Thoracic Surgery; Fellow of the American College of Surgeons. A practicing surgeon in Columbus, Dr. Kinsey was associated with University Hospital and with Riverside Hospital, and was physician for the Weirton Steel Company. Surviving are his widow, two children, his mother, and two brothers.

William Kutler, M. D., Cleveland; Ohio State University College of Medicine, 1926; aged 65; died May 4; former member of the Ohio State Medical Association. Dr. Kutler was a practicing physician and surgeon in Cleveland for about 42 years. Among affiliations he was a member of the Kiwanis Club and the Fairmount Temple. He is survived by his widow, a son, a daughter, two brothers, and two sisters.

Ruth E. Matthewson, M. D., Athens; Western Reserve University School of Medicine, 1954; aged 42; died May 16; member of the Ohio State Medical Association and the American Medical Association. A native of Nelsonville, Dr. Matthewson had been associated there for several years with the Hudson Health Center, and the Southeastern Ohio Guidance Center. She was active in the work of the Athens County Medical Society and was a member of the Presbyterian Church. Surviving are her parents and a sister.

Joseph Alexander Mack, M. D., Canton; State University of New York at Buffalo, School of Medicine, 1937; aged 59; died May 22 in a helicopter crash near Los Angeles while on a vacation trip; member of the Ohio State Medical Association and the American Medical Association. A native of Toledo, Dr. Mack had been a practicing physician in Canton for about 30 years and was a member of the Church of the Lakes. The accident was a family tragedy. Killed with him in the accident were his wife, his mother-in-law, a brother, and other close relatives. Surviving are three daughters, three sons, three brothers, and two sisters.

Amado S. A. Mauricio, M. D., Rising Sun, Ind.; University of Santo Tomas, Manila, 1953; aged 38; died May 30. Dr. Mauricio took his internship training at Deaconess Hospital, Cincinnati, and was formerly associated with St. Francis Hospital. Survivors are his widow, two sons, three daughters, his mother, three brothers and two sisters.

Emmett Augustus Moore, M. D., Newark; Baltimore Medical College, 1908; aged 86; died May 12; former member of the Ohio State Medical Association. Dr. Moore practiced in Newark from 1920 to 1938, specializing in the eye, ear, nose, and throat field. He was retired for a number of years. A member of the Elks Lodge, he is survived by his widow.

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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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Dudley Garfield Parker, M. D., Dayton; Howard University College of Medicine, 1959; aged 37; died May 21. Dr. Parker entered practice in Dayton after taking internship at Good Samaritan Hospital there. Among affiliations he was a member of the Unitarian Church and the Kiwanis Club. Survivors include his widow, two daughters, a son, his parents, three sisters, and a brother.

John Russell Peters, M. D., Glendale, Calif.; Ohio State University College of Medicine, 1928; aged 71; died February 20; former member of the Ohio State Medical Association; member of the American Psychiatric Association. A former practitioner in Chillicothe, records indicate that Dr. Peters left Ohio about 1935, went first to Kentucky and later to California.

Harold George Reineke, M. D., Cincinnati; University of Minnesota Medical School, 1923; aged 70; died May 16; member of the Ohio State Medical Association, the American Medical Association, American Roentgen Ray Society, Radiological Society of North America, and the American College of Radiology; diplomate of the American Board of Radiology. A Radiologist of long standing in Cincinnati, Dr. Reineke was formerly clinical professor of radiology at the University of Cincinnati College of

Medicine. He was a former president of the American Roentgen Ray Society.

Richard C. Schneble, M. D., Dayton; St. Louis University School of Medicine, 1930; aged 62; died May 23; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Cardiology and the American College of Chest Physicians. Dr. Schneble practiced for some 36 years in Dayton. He was a veteran of World War II, having served in the Navy Medical Corps. Survivors include his widow, a daughter, three sons, a sister, and a brother, Dr. Clem J. Schneble, also of Dayton.

William Royall Smith, M. D., Youngstown, Meharry Medical College, 1923; aged 72; died May 15; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A Youngstown physician for 45 years, Dr. Smith was associated with work in the YMCA, the NAACP, fraternal and church groups. Surviving are his widow, a daughter, and a son.

Harry Sneiderman, M. D., Cleveland; Yale University School of Medicine, 1923; aged 68; died May 2; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Pathology. A practicing pathologist of many years standing in Cleveland, Dr. Sneiderman was founder and director of the Clinical Pathological Laboratories there.

William Peter Young, M. D., Youngstown, Meharry Medical College, 1928; aged 71; died May 17; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A practitioner of long standing in the Youngstown area, Dr. Young formerly was president of the Mahoning County Chapter of the AAGP. He was a trustee of Central State College and received an honorary law degree from that institution. He received the local Chamber of Commerce Civic Improvement Award, was active in the Boy Scout movement, and was on the Campbell Board of Education. His widow survives.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during May. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Athens

Earl R. Berry, Athens

Butler

Pacifico Amaro, Hamilton
Richard P. Burkhardt, Oxford
Luvern C. Garling, Oxford
James I. Scott, Hamilton

Cuyahoga

James H. Butt, II, Cleveland
Maria M. Herenda, Cleveland
Flordeliza Ramos-Pascual, Northfield
Octubre A. Reyes, Cleveland

Hamilton

Malcolm W. Lentz, Cincinnati

Lorain

Francisco B. Leano, Elyria

Mahoning

John R. Madison, Youngstown
Anthony N. Pannozzo, Youngstown

Montgomery

John H. Boyles, Jr., Dayton
George P. Sperry, Dayton

Fourth Congress on Quackery

The Fourth National Congress on Health Quackery will be held in Chicago, October 2-3 at the Drake Hotel.

Joint announcement of the Congress was made from the American Medical Association and the National Health Council. "Protecting the Consumer" will be the theme of the meeting.

The Quackery Congress will be the opening event of "AMA Law Week," October 2-6. The Law Week program, also to be held at the Drake Hotel, is to include the Second National Congress on Medical Ethics and the biennial Legal Conference for Medical Society Representatives.

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Roster of Specialty Sections Chairmen and Secretaries

Following are names and addresses of chairmen and secretaries of the Ohio State Medical Association Specialty Sections, with some program chairmen. Most of these sections met during the OSMA Annual Meeting in Columbus and elected or re-elected officers. Specialty Sections aid the Committee on Scientific Work to plan programs for the Annual Meeting. These names and addresses are given for the benefit of persons who may wish to correspond with Section officers in regard to program matters.

Section on Anesthesiology—Chairman, Paul G. Cressman, M.D., 715 Second National Bldg., Akron 44308; Secretary, Merle Welch, M.D., University Hospital, Room 410, 15th and Neil Ave., Columbus 43210.

Section on Colon and Rectum—Chairman, Ralph B. Samson, M.D., 350 East Broad St., Columbus 43215; Secretary, J. S. Surdyk, M.D., 117 S. Main St., Dayton 45402.

Section on Directors of Medical Education — Chairman, Justus C. Pickett, M.D., 843 N. 21st St., Newark 43055; Secretary, Richard W. Juvancic, M.D., Trumbull Mem. Hosp., 1350 East Market St., Warren 44482.

Section on General Practice of Medicine — Chairman, Richard C. Brandes, M.D., 2094 Tremont Center, Columbus 43221; Secretary, Fred T. Suppes, M.D., 2154 Noble Rd., Cleveland 44112.

Section on Ear, Nose and Throat—Chairman, L. Reed Cranmer, M.D., 3939 Monroe St., Toledo 43606 (Also President, Ohio ENT Society); Secretary, Howard W. Lowery, M.D., 3545 Olentangy River Rd., Columbus 43214 (Also Secretary, Ohio ENT Society).

Section on Internal Medicine—Chairman, Carl G. Thompson, M.D., 938 Hempstead Dr., Cincinnati 45231; Secretary, Robert W. Jones, M.D., 120 Sturges Ave., Mansfield 44903.

Section on Neurological Surgery — Chairman, John N. Meagher, M.D., 1275 Olentangy River Rd., Columbus 43212 (Also President of Ohio Neurosurgical Society); Secretary, J. Hugh Webb, M.D., 3939 Monroe St., Toledo 43606 (Also Secretary of the Ohio Neurosurgical Society).

Section on Obstetrics and Gynecology—Chairman, Michael Howett, M.D., Dept. of Obstetrics & Gynecology, 3231 Burnet Ave., Cincinnati 45229; Secretary, Anthony S. Neri, M.D., 17 N. Harding Rd., Columbus 43209.

Section on Occupational Medicine—Chairman, Anthony M. Puleo, M.D., 1200 Babbitt Rd., Cleveland 44117; Secretary, James W. Loney, M.D., 15450 Hemlock Point Rd., Chagrin Falls 44022.

Section on Ophthalmology—Chairman, Clarence L. Hans, Jr., M.D., 630 Vine St., Cincinnati 45202; Secretary, William H. Havener, M.D., University Hospital, 320 West 10th Avenue, Columbus 43210.

Section on Orthopaedic Surgery — Chairman, Nicholas J. Giannestras, M.D., 71 East Hollister St., Cincinnati 45219 (Also President of Ohio Orthopaedic Society); Secretary: Paul R. Miller, M.D., 340 East State St., Columbus 43215 (Also Secretary of Ohio Orthopaedic Society).

Section on Pathology—Chairman, Lawrence McCormack, M.D., Dept. of Pathology, Cleveland Clinic, 2050 E. 93rd St., Cleveland 44106 (Also President of Ohio Society of Pathologists); Secretary, Robert G. Thomas, M.D., Dept. of Laboratories, Elyria Mem. Hospital, 630 E. River St., Elyria 44035 (Also Secretary of Ohio Society of Pathologists).

Section on Pediatrics—Chairman, Lester W. Sanders, Jr., M.D., 7777 Montgomery Rd., Cincinnati 45236; Secretary, Adelaide E. Sauers, M.D., 4373 E. Livingston Ave., Columbus 43227.

Section on Physical Medicine and Rehabilitation —Chairman, Emily R. Hess, M.D., Good Samaritan Hospital, Cincinnati 45220; Secretary, George W. Waylonis, M.D., Dept. of Physical Med., Children's Hospital, 17th at Livingston Park, Columbus 43205.

Section on Plastic Surgery—Chairman, Robin Anderson, M.D., 2020 East 93rd St., Cleveland Clinic, Cleveland 44106; Secretary, H. William Porterfield, M.D., 1100 Morse Rd., Columbus 43224; Program Chairman, deWayne Richey, M.D., 10525 Carnegie Avenue, Cleveland 44106.

Section on Psychiatry and Neurology—Chairman, James R. Hodge, M.D., 1540 West Market St., Akron 44313 (Also program chairman for section and society); Secretary, Milton Kramer, M.D., 3200 Vine St., Cincinnati 45220 (Also Secretary of the Ohio Psychiatric Association).

Section on Radiology—Chairman, Lee S. Rosenberg, M.D., Jewish Hospital, Cincinnati, Ohio 45229; Secretary, (to be announced).

Section on Rheumatic Diseases—Chairman, Roland W. Moskowitz, M.D., Terrace Park (Apt. 1103), 13800 Terrace Rd., East Cleveland 44112; Secretary, Joseph E. Levinson, M.D., 2825 Burnet Ave., Cincinnati 45219.

Ohio Specialty Organizations Presidents and Secretaries

Ohio Specialty Societies in many instances cooperated in sponsoring programs in connection with the Ohio State Medical Association Annual Meeting, many of them combining their programs with those of the OSMA Specialty Sections. Some organizations hold meetings at other times of the year. Following are names and addresses of officers of Specialty Societies announced to *The Journal* before this issue went to press.

Ohio Chapter, American College of Chest Physicians — President, John H. Kennedy, M.D., Metropolitan General Hosp., 3395 Scranton Rd., Cleveland 44109; Secretary, George O. Kress, M.D., 350 East Broad Street, Columbus 43215.

Ohio Ear, Nose and Throat Society — President, L. Reed Cranmer, M.D., 3939 Monroe St., Toledo 43606; (Also Chairman of Section on Ear, Nose and Throat); Secretary, Howard W. Lowery, M.D., 3545 Olentangy River Rd., Columbus 43214 (Also Secretary of Section on Ear, Nose and Throat).

Ohio Society of Internal Medicine — President, Clayton R. Sikes, Jr., M.D., 41 East Hollister St., Cincinnati 45219; Secretary, Carl G. Thompson, M. D., 938 Hempstead Drive, Cincinnati 45231 (Also Chairman of Section on Internal Medicine).

Ohio Neurosurgical Society — President, John N. Meagher, M.D., 1275 Olentangy River Rd., Columbus 43212 (Also Chairman of Section on Neurosurgical Surgery); Secretary, J. Hugh Webb, M.D., 3939 Monroe St., Toledo 43606 (Also Secretary of Section on Neurosurgical Surgery).

Ohio Ophthalmological Society — President, Russell N. Brown, M.D., Fair Main Medical Bldg., 1126 South Main St., Dayton 45409; Secretary, Robert H. Magnuson, M.D., 150 East Broad St., Columbus 43215.

Ohio Orthopaedic Society — President, Nicholas J. Giannestras, M.D., 71 East Hollister St., Cincinnati 45219 (Also Chairman of the Section on Orthopaedic Surgery); Secretary-Treasurer, Paul R. Miller, M.D., 340 East State St., Columbus 43215 (Also Secretary of the Section on Orthopaedic Surgery).

Ohio Society of Pathologists — President, Lawrence McCormack, M.D., Cleveland Clinic, 2050 East 93rd St., Cleveland 44106 (Also Chairman of Section on Pathology); Secretary, Robert G. Smith, M.D., Elyria Memorial Hosp., 630 E. River St., Elyria 44035 (Also Secretary of Section on Pathology).

Ohio Chapter, American Academy of Pediatrics — President, Homer A. Anderson, M.D., 196 East State St., Columbus 43215; Secretary-Treasurer, George A. Smith, M.D., 908 North Fountain St., Springfield 45504.

Ohio Society of Physical Medicine and Rehabilitation — President, Emily R. Hess, M.D., Good Samaritan Hosp., Cincinnati 45220 (Also Chairman of Section on Physical Medicine and Rehabilitation); Secretary-Treasurer, John L. Melvin, M.D., University Hospital, 410 West 10th Ave., Columbus 43210.

Ohio Psychiatric Association — President, Harold Hiatt, M.D., Holmes Hospital, Eden & Bethesda, Cincinnati 45219; Secretary, Milton Kramer, M.D., Psychiatry Dept., VA Hospital, Cincinnati 45220 (Also Secretary of Section on Psychiatry & Neurology); Executive Secretary, Mr. Gene P. King, 88 East Broad Street, Columbus 43215.

Ohio State Radiological Society — President, Mortimer Lubert, M.D., 10900 Carnegie Ave., Cleveland 44106; Secretary, Robert Berkebile, M.D., 33 Lakeview Drive, Grafton 44044.

Ohio Committee on Trauma, American College of Surgeons — Chairman, Wesley Furste, M.D., 3545 Olentangy River Rd., Columbus 43214; Secretary-Treasurer, Ray E. Ebert, M.D., 327 East State St., Columbus 43215; Program Chairman, Thomas Morgan, M.D., 1st Ave. and Cedar St., Gallipolis 45631.

Ohio Thoracic Surgery Society — President, Robert L. Taylor, M.D., Fidelity Medical Bldg., Dayton 45402; Secretary-Treasurer, H. Gene Ewy, M. D., 819 West Broad St., Columbus 43215.

Gift from Physician's Estate Goes to Kettering Lab

A $37,000 gift from the estate of the late Dr. Otto P. Geier has been presented to the Kettering Laboratory of the University of Cincinnati College of Medicine to help in the spread of information about occupational medicine.

Dr. Geier was noted as a pioneer in industrial medicine. As early as 1914 he installed at the Cincinnati Milling Machine Company one of the earliest medical departments in any industrial plant. He was likewise one of the founders of the American Association of Industrial Physicians and Surgeons. He served as president of the group in 1920 and 1921.

Plans are under way to establish the Otto Philip Geier Memorial Fund in the UC Department of Environmental Health. Dr. Geier died in 1954.— *Cincinnati Enquirer*

Ohio State Heart Association Report of Annual Election

Sanford R. Courter, M. D., of Cincinnati, assumed the role of president of the Ohio State Heart Association to succeed George Morrice, Jr., M. D., of Newark, at the Association's annual meeting in Cincinnati on May 15.

Simon Koletsky, M. D., of Cleveland, was elected secretary of the Association to replace A. P. Ormond, Sr., M. D., of Akron. William H. Bunn, Jr., M. D., of Youngstown, is a new member of the executive committee.

J. Lester Kobacker, M. D., of Toledo, Jack S. Silberstein, M. D., of Columbus, John W. Martin, M. D., of Cleveland, and Dr. Morrice were renamed to the executive committee.

Physicians appointed to the OSHA Board to represent their respective chapters include: Drs. William Falor, of Akron; Neil C. Andrews and C. Joseph Cross, of Columbus; Frederick S. Cross, Ray W. Gifford, Jr., and Simon Koletsky, of Cleveland; Victor Strauss and Samuel Kaplan, of Cincinnati; Robert E. Rinderknecht, of Dover; Richard G. Spitzer of Canton; Angelo Riberi, of Youngstown; A. A. Brust and Benjamin Schuster, of Dayton; C. Douglass Ford and R. P. Whitehead, of Toledo.

Physician representative delegates appointed by the chapters include: Drs. John Kramer, of Akron; Wayne W. Schroyer, of Ravenna; Alan E. Sheline, of Columbus; Oscar W. Clarke, of Gallipolis; Robert A. Heiny, of Washington Court House; Louis A. Black, of Kenton; Philip W. Smith, of Marion; Albert H. Voegele, of Mansfield; Bernard L. Charms, Harriet P. Dustan, Hermann Menges, Jr., Thomas C. Lloyd and Richard W. Watts, of Cleveland; Florence Takacy, of Willoughby; Noble O. Fowler, of Cincinnati; Thomas E. Fox, of Mason; Russell L. Malcolm, Jr., of Middletown; Howard C. MacMillan, of Wooster; William Bogedain, of Canton; Morris S. Rosenblum, of Youngstown; Richard Juvancic, of Warren; William B. Martin, and Elvin C. Hedrick, of Dayton; and Howard E. Smith, of Toledo.

Dr. Vol K. Philips, Columbus, received a distinguished award from the National Arthritis Foundation. The award was presented at the national meeting in New York.

Surgeons and surgical specialists from virtually every country of the world will gather in Tokyo, Japan beginning October 6, 1968 for the Sixteenth Biennial International Congress sponsored by the International College of Surgeons. Among internationally renowned surgeons who are scheduled to address the convention is Dr. Richard W. Zollinger, Columbus.

Resignation Opens Quest for Medical Board Secretary

Dr. W. Thomas Washam, Executive Secretary of the State Medical Board of Ohio, has resigned from that position effective August 1. Any qualified physician interested in seeking the office is invited to apply to the State Medical Board of Ohio, 21 West Broad Street, Columbus, Ohio 43215. Successful applicant must be a citizen of the United States and a physician licensed to practice in Ohio.

Dr. Washam resigned to re-enter the private practice of medicine.

Agricultural Ammonia Burns and Emergency Steps Recommended

A pamphlet entitled "NH_3 — Agricultural Ammonia Emergency" published by the Agricultural Nitrogen Institute emphasizes the importance of prompt first-aid and medical attention for persons suffering ammonia burns. Here are emergency steps the institute recommends:

1. **Water** is the best emergency first aid treatment for ammonia burns. Keep adequate supply of clean water immediately available.

2. **Time Is Important!** Get water onto the injured area of skin or eye immediately. If burns are extensive and water tank is available get victim into water.

3. **Flush or Irrigate** exposed area with water for at least 15 minutes.

4. **Warning!** Do not apply salves, ointments or oils to an ammonia burn for at least 24 hours.

5. **Contaminated Clothing** should be removed as soon as practical. Because of freezing action of anhydrous ammonia, clothing may be frozen to skin in which case thaw with water first.

6. **Keep Victim Warm!** Get him to a physician and tell him that ammonia caused the injury.

7. **Breathing Stopped.** If victim has stopped breathing begin artificial respiration immediately and administer oxygen. Approved resuscitators may be used.

Persons who have experienced inhalation of dangerous concentrations of ammonia vapor should be closely observed for a 24-hour period.

Dr. Jesse L. Heise, of Pitsburg in Darke County, recently left with his family for a year's medical service tour in Africa. He will serve at a church-operated hospital near Choma in Zambia.

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Headquarters Office: 17 S. High St.—Suite 500, Columbus 43215. *Telephone: (614) 228-6971*

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Councilor: Paul N. Ivins, Hamilton 45011
306 High Street

ADAMS—Gary J. Greenlee, President, Farmers' National Bank, Manchester 45144; Hazel L. Sproull, Secretary, Box 337, West Union 45693. 3rd Thursday, January, April, July, and October.

BROWN—Philip A. Pealzgraf, President, 1830 Ohio Pike, Route 1, Batavia 45103; Robert S. Benintendi, Secretary, 117 West Cherry Street, Georgetown 45121. Meetings monthly.

BUTLER—Walter H. Roehill, Jr., President, 701 North University Boulevard, Middletown 45042; Mr. E. Clifford Roberts, Executive Secretary, 110 North Third Street, Hamilton 45011. 4th Wednesday monthly.

CLERMONT—G. Franklin Lowe, President, Cemetery Road, Milford 45150; Raymond L. Davidson, Secretary, 684 Batavia Pike, Cincinnati 45245. 3rd Wednesday monthly.

CLINTON—David Hamilton, President, 615 West Main Street, Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Stanley D. Simon, President, 708 Doctors Building, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday monthly.

HIGHLAND—Thomas L. Jones, President, 528 South Street, Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson Street, Greenfield 45123.

WARREN—George A. Rourke, President, 210 Mound Street, Lebanon 45036; Ray E. Simendinger, Secretary, 901 North Broadway, Lebanon 45036. 2nd Tuesday monthly.

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Councilor: George J. Schroer, Sidney 45367
322 Second Ave.

CHAMPAIGN—Stephen V. Rader, President, 113 Miami Street, Urbana 43078; T. Grogan, Secretary, 848 Scioto Street, Urbana 43078. 2nd Wednesday monthly.

CLARK—Martin J. Cook, President, 1051 East High Street, Springfield 45505; Mrs. Marion L. Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone Street, Springfield, Ohio 45503. 3rd Monday monthly.

DARKE—Ross M. Zeller, President, 414 Walnut Street, Greenville 45331; Giles Wolverton, Secretary, Health Department, Court House, Greenville 45331. 3rd Tuesday monthly.

GREENE—Cary B. Gardner, President, 1182 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly, except July and August.

MIAMI—John Gallagher, President, 145 Sunset Drive, Piqua 45356; Al C. Howell, Secretary, 6650 Tipp-Cowlesville Road, Tipp City 45371. 1st Tuesday monthly.

MONTGOMERY—Peter A. Granson, President, 1100 South Main Street, Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly.

PREBLE—J. D. Darrow, President, 228 North Barron Street, Eaton 45320; J. R. Williams, Secretary, 401 North Barron Street, Eaton 45320.

SHELBY—George J. Schroer, President, 322 Second Avenue, Sidney 45365; Alfonsas Kisielius, Secretary,Ohio Building, Sidney 45365. Meetings every three months.

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Councilor: Frederick T. Merchant, Marion 43302
1051 Harding Memorial Pky.

ALLEN—Nathan Kalb, 904 Cook Tower, Lima 45801; T. E. Bilon, Secretary, 908 Cook Tower, Lima 45801. 3rd Tuesday monthly.

AUGLAIZE—Herbert Wolfe, President, Box 238, New Knoxville 45871; Dale Kile, Secretary, 112 Court Street, Saint Marys 45885. 1st Thursday every other month.

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3939 Monroe St

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FULTON—F. E. Elliott, President, 203 Beech Street, Wauseon 43567; R. L. Davis, Secretary, 137 South Fulton Street, Wauseon 43567. 2nd Tuesday, March, June, September, and December.

HENRY—T. F. Moriarity, President, 651 Strong Street, Napoleon 43545; W. J. Stough, Secretary, 515 Avon Place, Napoleon 43545.

LUCAS—J. S. Kozy, President, 3672 Rugby Drive, Toledo 43614; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Boulevard, Toledo 43610. 3rd Tuesday monthly, except July and August.

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PAULDING—Richard D. Stagg, President, Merrin and Laura Streets, Payne 45880; Kirkwood A. Pritchard, Secretary, 119 South Main Street, Paulding 45879. Called meetings.

PUTNAM—James B. Overmeir, President, 109 Main Street, Leipsic 45856; Arthur P. Daniel, Secretary, 144 North Walnut Street, Ottawa 45875. 1st Tuesday monthly.

SANDUSKY—E. C. Hiestand, President, Old Fort 44861; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.

WILLIAMS—N. T. Levenson, President, Central Drive, Bryan 43506; P. G. Meckstroth, Secretary, Central Drive, Bryan 43506. 3rd Tuesday monthly.

WOOD—Gerald G. Woods, President, 513 Superior Street, Rossford 43460; L. J. Eulberg, Secretary, Pemberville 43450. 3rd Thursday monthly.

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CUYAHOGA—Elden C. Weckesser, President, 10465 Carnegie Avenue, Cleveland 44106; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106. Board of Directors meets 2nd Tuesday monthly.

GEAUGA—Arturo Dimaculangan, President, Geauga Medical Park, 13241 Ravenna Road, Chardon 44024; Mrs. Martha S. Withrow, Executive Secretary, P. O. Box 249, Chardon 44024. 2nd Friday monthly.

LAKE—Carl G. Madsen, Jr., President, 168 East High Street, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening, bimonthly, except June, July, and August. (January, March, May, September, and November.)

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STARK—Wm. D. Baker, President, 1696 South Arch Street, Alliance 44601; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday monthly.

SUMMIT—D. W. Mathias, President, 819 First National Tower, Akron 44308; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 1st Tuesday monthly.

TRUMBULL—Donn F. Covert, President, 200 Garfield Drive, N. E., Warren 44483; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday monthly.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth Street

BELMONT—E. V. Arbaugh, Jr., President, 414 Jefferson Street, Martins Ferry 43935; Bertha M. Joseph, Secretary, 100 South Fourth Street, Martins Ferry 43935. 3rd Thursday, except January, May, July, and August.

CARROLL—C. H. Dowell, President, 103 West Main Street, Carrollton 44615; T. J. Atchison, Secretary, 292 East Main Street, Carrollton 44615. 1st Thursday monthly.

COSHOCTON—Don Potts, President, 600 East Main Street, West Lafayette 43845; H. W. Lear, Secretary, 133 South Fourth Street, Coshocton 43812. 2nd Tuesday monthly.

HARRISON—Charles Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988. Quarterly, March, June, September, and December.

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MONROE—Byron Gillespie, Secretary, Woodsfield, Ohio 43793.

TUSCARAWAS—Thomas E. Ogden, President, 146 East Main Street, Gnadenhutten 44629; Efrain Padro, Secretary, 200 West 2nd Street, Dover 44622. Four meetings a year minimum. Generally held 2nd Thursday of month or a preceding Wednesday dinner meeting.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson

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FAIRFIELD—John W. Edwards, President, 435 East Main Street, Lancaster 43130; Carl R. Reed, Secretary, 124½ West Main Street, Lancaster 43130. 2nd Tuesday monthly 11:30 A. M.

GUERNSEY—Joseph Goggin, President, Medical Arts Building, Cambridge 43725; Quentin F. Knauer, Seoretary, 100 Clark Court, Cambridge 43725. 1st Tuesday monthly.

LICKING—Paul N. Montalto, President, Moundbuilders Drs. Park, 1272 West Main Street, Newark 43056; Robert P. Raker, Secretary, 117 East Elm Street, Granville 43023. 4th Tuesday monthly.

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Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street. Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

EMERGENCY ROOM PHYSICIAN — Excellent opportunity for young physician interested in full-time practice of Emergency Room care. Join a physician group responsible for the emergency service of two major Cincinnati hospitals. Remuneration on a fee-for-service basis with guaranteed minimum. Must have or be eligible for Ohio license. Send resume to P. O. Box 36163, Cincinnati, Ohio 45236.

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(Continued from Previous Page)

GENERAL PRACTITIONER OR INTERNIST — Full-time staff physician needed for Domiciliary Medical Service in 766-bed general medical and surgical hospital. Ohio State University Medical College affiliation. Faculty members conduct conferences, clinics, and participate in a diversified residency training program. Medical license in any state acceptable; salary range $15,841 to $21,469 per annum depending upon qualifications. Maximum leave and insurance benefits; noncitizens will be considered; nondiscrimination in employment. Write: Center Director, Veterans Administration Center, 1100 West Third Street, Dayton, Ohio 45428.

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OHIO STATE MEDICAL

The Ohio State Medical Journal

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AUGUST 1968

VOLUME 64 ★ NUMBER 8

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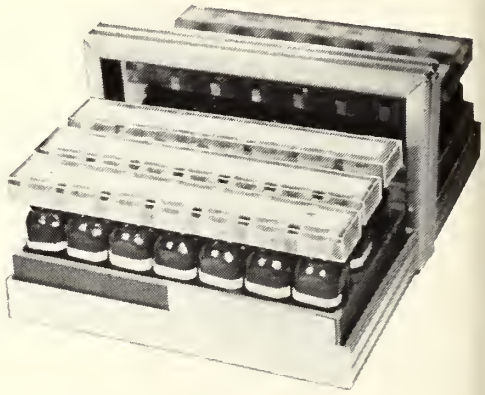
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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Eyleman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: FFNT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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The OHIO STATE MEDICAL Journal

VOL. 64 AUGUST, 1968 No. 8

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Address All Correspondence:
The Ohio State Medical Journal
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Columbus, Ohio 43215

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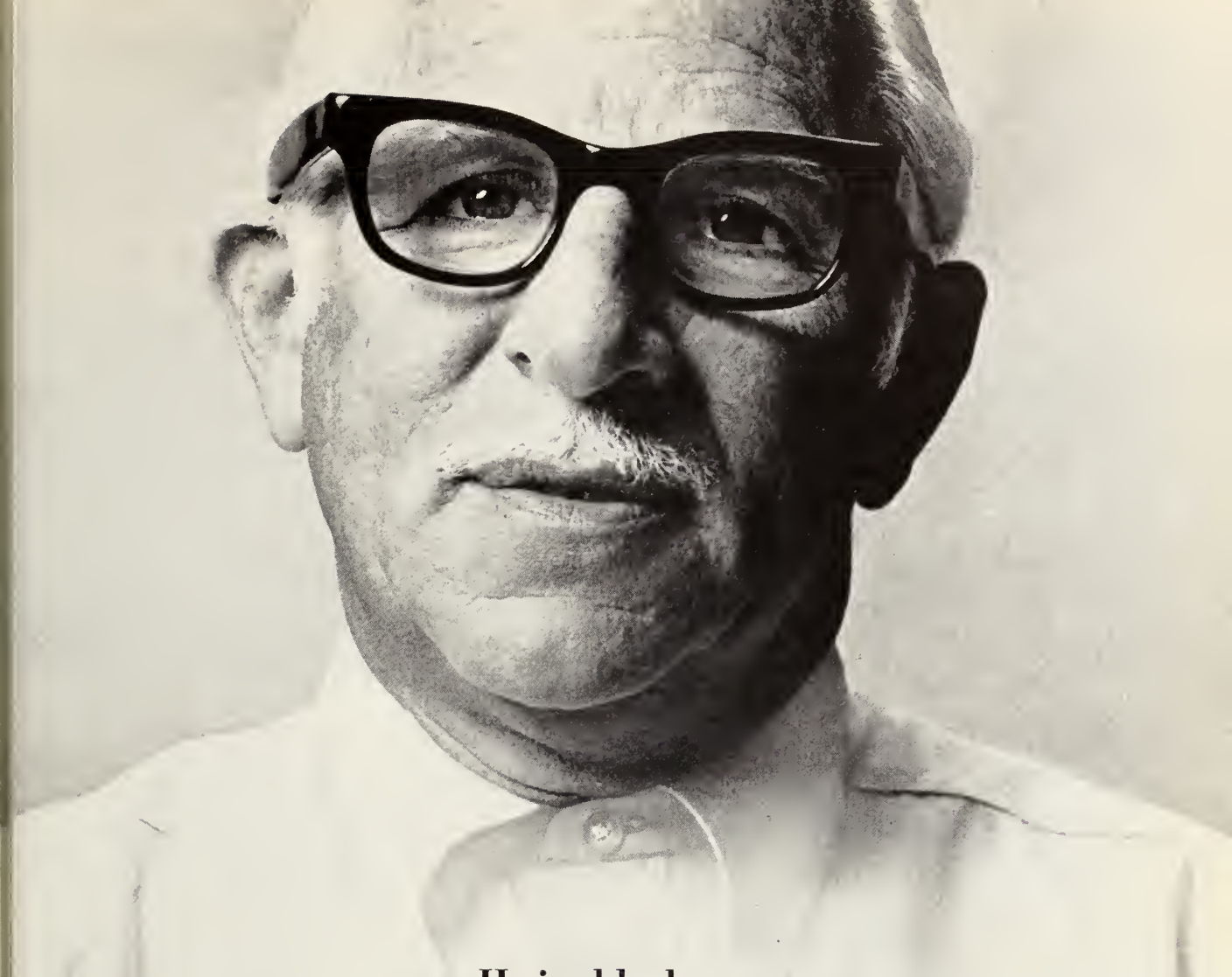
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autions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Allied Medical Professions Unit At OSU Given Green Light

Plans are under way for the construction of a 10th building in the medical center at Ohio State University. The new facility will house all divisions of the College of Medicine's School of Allied Medical Professions.

Officials of the university have received formal notice of a $1,791,920 award for the building from the U.S. Department of Health, Education, and Welfare. This is the first construction grant award to be given under provisions of Public Law 89-751, the Allied Health Professions Personnel Training Act of 1966.

Plans call for construction to begin in July, 1969. The building with its equipment is expected to cost some $4 million, with the State of Ohio providing matching funds from the bond issue approved by Ohioans in 1963.

Dr. Robert J. Atwell, director of the School of Allied Medical Professions at Ohio State, said the new building will provide space to develop new educational areas within the scope of AMP to meet the growing need for health related specialists.

Present plans are that the school will expand from seven to 13 divisions. The expansion calls for the development of areas which, he said, never before have been included in a formal college curriculum. These are divisions in extracorporeal technology and medical communications.

Other new divisions to be proposed will include medical records administration, hospital and health services administration, inhalation therapy and radiologic technology.

The new building also will allow for an expansion of the school's enrollment from the current 256 undergraduate and graduate students to a total of 599 undergraduates and 113 graduate students. It is anticipated that faculty for the school will expand from 30 to 87 full-time members.

This expansion will make the school the largest among the schools of allied medical professions in the United States, Dr. Atwell pointed out.

The new building will be five stories high and will be constructed on Perry Street, south of University Hospitals in the expanded area of the main campus. Included in the building plans are classrooms, administrative offices and specialized laboratories for the various divisions.

Two unique areas of the building will be those for the divisions of medical illustration and medical communications. The medical illustration area will include facilities for artists' and photographic studios, as well as darkrooms and equipment areas.

Medical communications will house motion picture and television studios and control rooms, dressing rooms and all facilities needed to produce both live and taped radio and television programs. The

area will be the central distribution point for all audiovisual programs in the medical center.

The School of Allied Medical Professions is currently housed in three separate buildings in the medical center and has only one classroom assigned specifically to it. Existing programs include medical dietetics, medical technology, occupational therapy, physical therapy, medical illustration, nurse anesthesiology and orthoptic technology.

Architects for the new building are Holroyd and Myers of Columbus.

Popular Today's Health Guide Now in Revised Edition

A revised edition of *Today's Health Guide,* has been published by the American Medical Association. This is the manual of health information and guidance for the family, the first edition of which proved popular with the American people.

It is an up-to-date family health reference recommended for use in the home—the product of some 200 of the world's most renowned authorities in medicine, science, and the allied fields.

In easy-to-understand language, the *Guide* discusses more than 2,000 illnesses, diseases, and other medical subjects including diet and nutrition, child care, safety and first aid, sex education, mental health and when to seek professional medical attention. Over 300 illustrations and an eight-page, full-color transparency of the human body vividly complement the text.

In attractive hard-back book form, *Today's Health Guide* is sold at the production cost of $5.00. Order from the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

Ohio Physicians Are on National Plastic Surgery Program

The American Academy of Facial Plastic and Reconstructive Surgery met in Hollywood Beach, Florida, April 27-30. Among physicians on the program were the following Ohioans who spoke on the topics indicated:

Dr. Trent Smith, Columbus, associate clinical professor of otolaryngology at Ohio State University, and chief of the Department of Otolaryngology, Children's Hospital, participated in a panel discussion on "Rhinoplasty."

Dr. Raymond S. Rosendale, Canton, director of education at Mercy Hospital, was member of a panel on "Management of Facial Fractures," and was moderator of a group for a "Symposium on Medico-Legal Matters."

Dr. Donald A. Shumrick, Cincinnati, professor and director of the Department of Otolaryngology and Maxillofacial Surgery, University of Cincinnati College of Medicine, presented a paper on the topic, "Utilization of Local Flaps for Head and Neck Defects."



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MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.

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Almost a Million Ohioans Have Heart Disease, Study Shows

Statistical studies made by the American Heart Association reveal that an estimated 927,000 Ohioans over the age of 20 have some form of heart disease according to the Ohio State Heart Association. This, however, does not represent the total prevalence of cardiovascular disease.

Not included in the study, due to lack of available data, were stroke for all ages, hypertension without heart disease for all ages and heart disease under age 20.

For the entire nation the Heart Association estimates that 17,205,000 Americans have one or more types of definite heart disease. This includes persons with coronary, hypertensive, rheumatic, congenital, syphilitic and other forms of heart disease.

The estimates were prepared by projecting 1960-62 data collected in the National Health Examination Survey by National Center for Health Statistics and taking into account such factors as age, sex, race and mortality in each state as of 1966.

Associate Director Added at OSU for Continuing Education Program

Dr. Richard L. Meiling, dean of the College of Medicine at Ohio State University, has announced the appointment of Robert B. Schweikart, Ph.D., to the post of associate director of the Center for Continuing Medical Education.

Dr. Schweikart has been associated with the College of Medicine since he received his Ph.D. degree from Ohio State in 1964. He has been director of the Ohio Medical Education Network, a group of 14 FM radio stations which broadcast live two-way discussions between physicians and nurses at the college and their colleagues in nearly 70 community hospitals in Ohio and surrounding states.

Expansion of the center is expected as new programs are developed to meet these needs of health related personnel.

Director of the Center for Continuing Medical Education is Dr. William G. Pace, assistant dean of the college.

What To Write For

Thinking About Drinking. This U. S. Public Health Service pamphlet is planned for distribution to young people as the basis for discussion of attitudes about drinking. The USPHS recommends it for distribution by youth group leaders, teachers, physicians, clergymen, neighborhood workers, driver education instructors, etc. Limited free copies available from Public Information Branch, National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20203.

* * *

AMA Health Education Materials — Catalog. This leaflet describes in detail the nearly 100 pamphlets and two sets of full-color posters available at nominal costs. The pamphlets and charts are suitable for use by physicians to supplement their counsel to patients, for distribution within organizations, and for use by teachers, coaches, etc. Order from the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

* * *

Selecting Automobile Safety Restraints for Small Children. This new Public Health Service pamphlet describes various types of children's safety seats and harnesses now available on the market.

For a free copy, write: Office of Information, National Center for Urban and Industrial Health, Injury Control Program, 222 East Central Parkway, Cincinnati, Ohio 45202.

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Urges Medical School Reappraisal Of Family Practice Training

Medical schools should reappraise the training and function of the family physician within the framework of their own academic communities, says a report published in the Communications Section of the June, 1968 issue of *The Journal of Medical Education,* the official publication of the Association of American Medical Colleges (AAMC).

The report was drafted last winter by a committee appointed by the Executive Council of the AAMC and chaired by Dr. Edmund Pellegrino, Director of the Medical Center, State University of New York.

A copy of the report is available by writing to the Association of American Medical Colleges, 2530 Ridge Avenue, Evanston, Illinois 60201.

The Executive Council of the AAMC has gone on record as urging the faculty of each medical school, and others interested, to study points raised by the Pellegrino report.

According to the report, "The task of today's medical schools can be no less than the 'creation of the future' in the field of health care. To this end, they must apply to relevant social issues the same intellectual and practical resources they have applied so well to scientific questions, and, they must do so before the forces of change make the future too painfully obvious."

The report also proposes that the matrix of medical care must be regionalized so as to provide differing levels and complexities of service in the smaller communities, the community hospital and the university medical centers.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during June. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Clermont
Francis E. Demarais, Batavia

Cuyahoga
Bernard T. Archer, Cleveland
Ernesto J. Arze, Cleveland
Amedeo Colucci, Cleveland
Demetria T. Fernandez, Cleveland
Lawrence R. Levy, Cleveland
Chester W. White, Jr., Cleveland

Defiance
Paul E. Brose, Defiance

Erie
Jairo J. Quintero-Chica, Sandusky

Franklin
Robert L. Folk, Columbus
Wallace N. Jensen, Columbus
George W. Paulson, Columbus
George W. Lewis, Columbus
Donald L. Nofziger, Columbus

Hamilton
George Benzing III, Cincinnati

Montgomery
Sharif M. Baig, Dayton
Robert E. Collins, Dayton
Jose G. Duarte, Dayton
Jerome A. Logan, Dayton
Kathe L. Mueller, Dayton

Portage
Apolinario A. Marquinez, Kent

Richland
Stephen Banko, Mansfield
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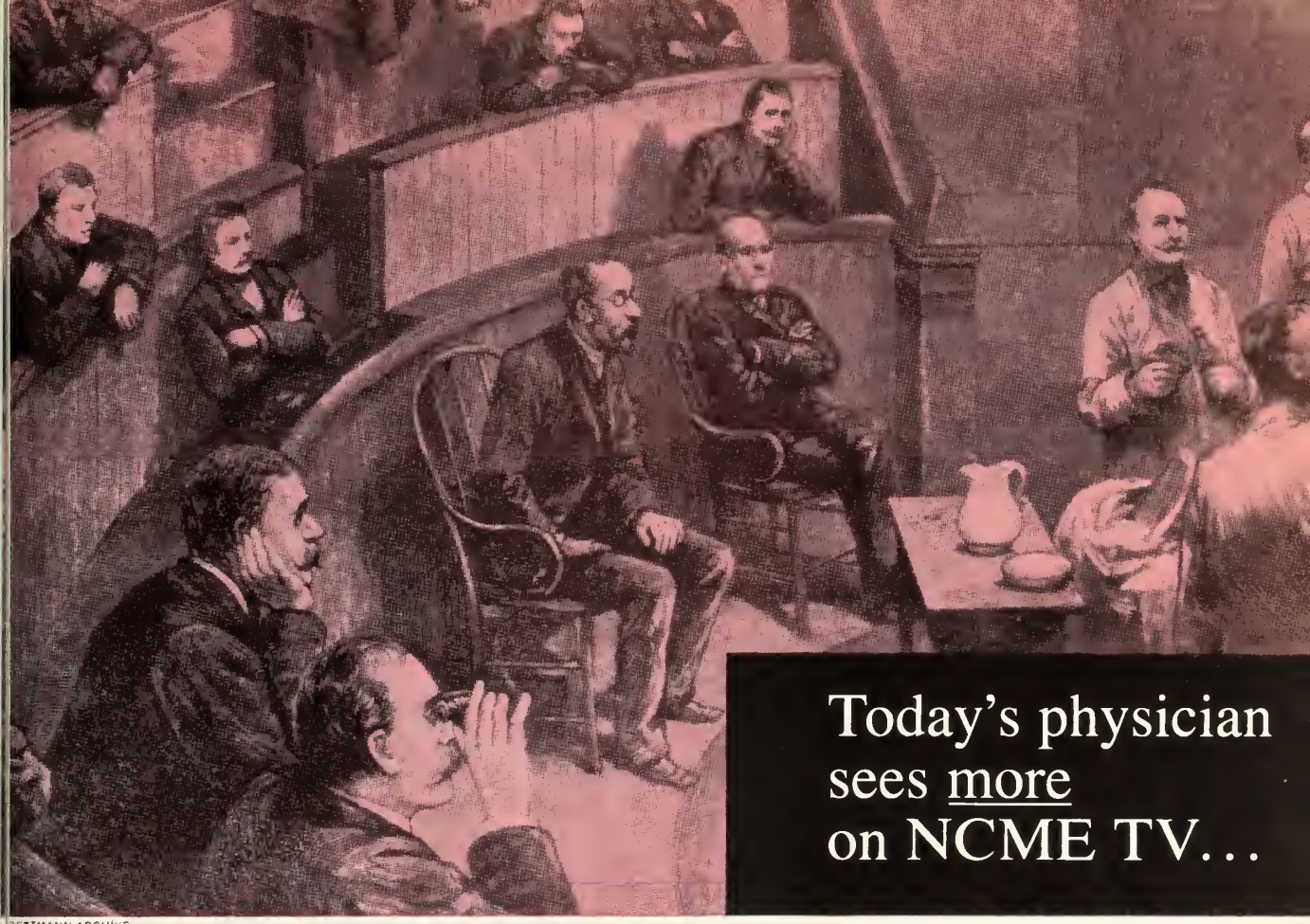
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☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

Family of Physicians Enjoy Alumni Reunion



These three members of the Ferris family of physicians enjoyed their own get-together at the University of Cincinnati Medical Alumni Association reunion held recently.

Dr. Frank Ferris, class of 1902, at the age of 95 is one of the College of Medicine's two oldest living graduates, alumni records show. Dr. Ferris was 29 years old when he received his medical degree. With offices in the Union Central Building in Cincinnati for many years, he specialized in the ear, nose and throat field. His present address is the Kenwood Terrace Extended Care Facility, Montgomery and Keller Roads in Cincinnati.

Dr. Ruth Ferris, left, a general practitioner in Cincinnati, is a graduate of the former Eclectic Medical College of Cincinnati. Dr. Frank Ferris is her husband's uncle.

Dr. Dorothy Ferris, right, University of Cincinnati College of Medicine, class of 1933, is a niece of the elder Dr. Ferris. She was in Cincinnati on a brief visit from her post in Ferozepore, Punjab, India, where she is medical superintendent and consultant in gynecology and obstetrics at the Frances Newton Hospital. She first went to India as a medical missionary in 1935. The hospital, formerly a Presbyterian institution, now belongs to the United Church of Northern India.

Both Dr. Frank Ferris and Dr. Ruth Ferris attended the 1968 Annual Meeting of the Ohio State Medical Association, held in Cincinnati, May 13-17.

Michigan State Annual Meeting Week of September 22

The Michigan State Medical Society's 1968 Annual Session is scheduled in Detroit the week beginning September 22. Headquarters will be the Sheraton-Cadillac Hotel.

Meetings of the House of Delegates and other preliminary functions are scheduled on Sunday, Monday, and Tuesday, September 22, 23, and 24. Much of the Scientific program will be on Wednesday and Thursday, September 25 and 26.

Additional information may be obtained from the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Mich. 48823.



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

You won't have to wait for these results to come back from the lab. Because now you can do blood chemistry tests in your own office. With Diagnostest* reagents and instruments. You get accurate, precise results in minutes. And we teach your nurse or medical assistant to do the tests. The system can be used to measure hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. Write today for full details.

*Trademark of The Dow Chemical Company

DOW



Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

Pain Break" for an osteoarthritic.

Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

te a latent peptic ulcer. The patient should instructed to take doses immediately after eals or with milk to minimize gastric upset. ug rash occasionally occurs. If it does, mptly discontinue the drug. Agranulocysis, exfoliative dermatitis, Stevens-Johnson ndrome, Lyell's syndrome (toxic necrotizg epidermolysis) or a generalized allergic action similar to a serum sickness syome may occur and require permanent thdrawal of medication. Agranulocytosis n occur suddenly in spite of regular, reated normal white counts. Stomatitis, saliry gland enlargement, vomiting, vertigo and nguor may occur. Leukemia and leukemoid actions have been reported. While not definely attributable to the drug, a causal relanship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

For complete details, please see full Prescribing Information.

Geigy

(B) 46-800-A

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TA-6806AR

Children's Developmental Research Unit Dedicated in Cincinnati

Dedication ceremonies were held recently in the auditorium of the Children's Hospital Research and Clinic Building in Cincinnati for the newly completed Institute for Developmental Research.

Ground for the Institute was broken May 2, 1966. Construction cost of $3,040,000 was financed by a $2,074,657 grant from the National Institutes of Health and the remainder by funds of the Children's Hospital Research Foundation.

The eight-story building has 76,000 square feet of floor space, an area which doubles the research facilities of the hospital and quadruples the laboratory animal space.

Dedication speakers included Dr. Clifford G. Grulee, Jr., UC Medical College dean; James M. Ewell, president, and Bishop Roger W. Blanchard, chairman of the board of trustees, Children's Hospital and Research Foundation; Dr. Edward L. Pratt, director, Research Foundation, and chief of staff of Children's Hospital; and Dr. Gerald D. LaVeck, director, National Institute of Child Health and Human Development of the National Institutes of Health.

Closely associated with the dedication was presentation of the annual Benjamin Knox lectures at Children's Hospital. Lecturers for the occasion were Dr. Robert A. Aldrich, professor of pediatrics, University of Washington; Dr. Edward L. Tatum, Rockefeller University and recent Nobel laureate; Dr. Albert B. Sabin, UC distinguished service professor of research pediatrics; Dr. Kurt Benirschke, professor and chairman of department of pathology, Dartmouth Medical School; and Dr. Richard J. Blandau, professor, department of biological structure, University of Washington.

Youngstown Hospital Establishes Nursery Intensive Care Unit

The North Unit of Youngstown Hospital has established an Intensive Care Unit in the Premature Nursery for high-risk premature and other infants.

According to Dr. Robert A. Wiltsie, chief of pediatrics, and Dr. Raymond S. Lupse, chief of OB-gyn, eight Intensive Care bassinets to care for premature babies and babies born of diabetic mothers, or by cesarean section, or in some other way considered to be of high-risk will be available for automatic assignment during the critical period of the first 24 hours.

Such facilities as oxygen, resuscitation equipment, intravenous therapy, ultrasound equipment for constant monitoring of the neonatal heart (also used to monitor the fetal heart), and personnel trained specifically in the health care of infants, in addition to the intensive care equipment, will be in readiness in this new combination Premature Nursery and Intensive Care Section.

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the antacid puzzle

In peptic ulcer:



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.
(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

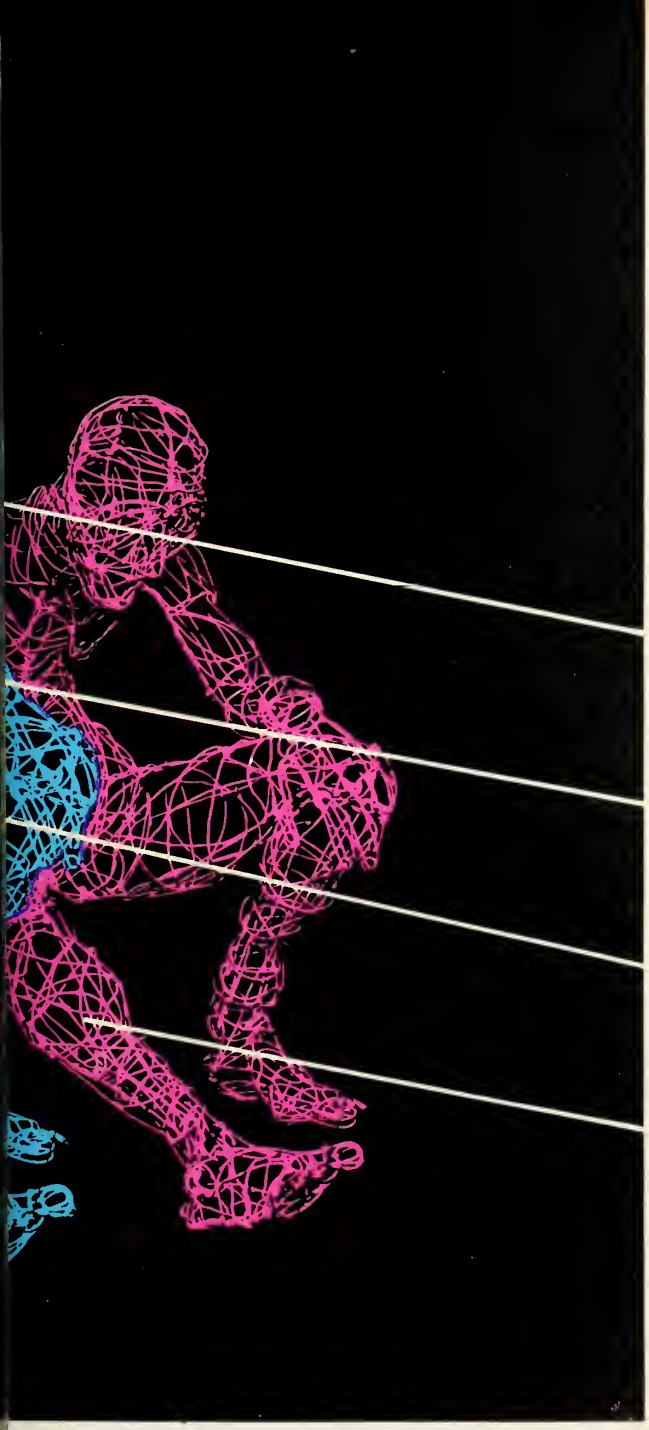
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appro investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without ade vitamin B_{12} therapy may result in hematologic remission but rological progression. Adequate doses of vitamin B_{12} (paren or oral with potent intrinsic factor as in Trinsicon® [hem concentrate with intrinsic factor, Lilly]) usually prevent, ha improve the neurological changes.

As with all preparations containing intrinsic factor, resist may develop in some cases of pernicious anemia to the pote tion of absorption of physiological doses of vitamin B_{12}. If r ance occurs, parenteral therapy, or oral therapy with so-c massive doses of vitamin B_{12}, may be necessary. No single men fits all cases, and the status of the patient observe follow-up is the final criterion for adequacy of therapy. Per



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

nical and laboratory studies are considered essential and are ommended.

verse Reactions: In rare instances, iron in therapeutic doses oduces gastro-intestinal reactions, such as diarrhea or constiion. Reducing the dose and administering it with meals will nimize these effects.

n extremely rare instances, skin rash suggesting allergy has owed oral administration of liver-stomach material. Instances apparent allergic sensitization have also been reported after l administration of folic acid.

sage: One Pulvule twice a day. (Two Pulvules daily produce a ndard response in the average uncomplicated case of pernius anemia.)

w Supplied: Pulvules Trinsicon® (hematinic concentrate with rinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

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choose an experienced candidate—
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(diphenhydramine hydrochloride)

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Supplied in various dosage forms including Kapseals,® containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

47968

Tuberculosis Hospitals Designated By State Health Director

The following communication entitled "Annual Designation of Tuberculosis Hospitals" was addressed to health commissioners and boards of county commissioners by Emmett W. Arnold, M. D., director of the Ohio Department of Health, and was released by Dr. Arnold for the information of the medical profession.

Pursuant to Section 339.20 of the Ohio Revised Code, the following tuberculosis hospitals have been designated in addition to the state tuberculosis hospitals as those needed to provide sufficient beds for all residents of the State of Ohio requiring maintenance, care, and treatment for tuberculosis on and after October 1, 1968:

Benjamin Franklin Hospital, Columbus

Dunham Hospital of Hamilton County, Cincinnati

Lowman Pavilion, Cleveland Metropolitan General Hospital, Cleveland

Ottawa Valley Hospital, Lima

Sunny Acres, Cuyahoga County Tuberculosis Hospital, Cleveland

William Roche Memorial Hospital, Toledo

You are further advised that effective October 1, 1968, as provided in Section 339.43 of the Ohio Revised Code, the State of Ohio will pay to the board of trustees, or to the board of county commissioners serving as a board of trustees, of any county, district, or other tuberculosis hospital, designated by the Director of Health, as provided in Section 339.20 of the Revised Code, the sum of five dollars per day for each patient hospitalized for the treatment of tuberculosis in such hospital by any county, and for whose care and treatment the county was legally obligated to pay, to be credited to the county in which the patient has legal residence as part payment of the per diem charge for the hospitalization of such patient.

The board of trustees of each such county, district, or other hospital shall, not later than the fifteenth day of each month, certify to the Auditor of State, on forms provided by the Auditor of State, the number of persons hospitalized during the preceding month for the care and treatment of tuberculosis, the number of days each such person was a patient, the name of such patient, and the county of his legal residence. Upon receipt of such certification, the Auditor of State shall draw warrants in the amount found to be due, on the Treasurer of State, payable out of the general revenue fund, in favor of the trustees of such county, municipal, or district tuberculosis hospital.

State subsidy will not be paid to tuberculosis hospitals that have not been designated under the provisions of Section 339.20 of the Ohio Revised Code.

* * *

Per Diem Rate Announced

The following additional memorandum was issued by Dr. Arnold in regard to per diem rate at the Tuberculosis Service.

This is to advise you that the per diem rate to be charged for care and treatment of patients admitted to the tuberculosis service at the Ohio State University and the Southeast Ohio Tuberculosis Hospital will be thirty dollars ($30.00) effective October 1, 1968. This rate has been established pursuant to sections 3335.44 and 3701.83 of the Revised Code.



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

REPORT ON EXAMINATION OF FINANCIAL STATEMENTS, YEAR ENDED DECEMBER 31, 1967

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the statement of assets of the Ohio State Medical Association at December 31, 1967, and the related statement of cash receipts and disbursements of the Executive Secretary and the Treasurer and the statement of operations of The Ohio State Medical Journal for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

The statements of The Ohio State Medical Journal included herein have been prepared on the accrual basis of accounting. The accounts of the Executive Secretary and the Treasurer included herein have been prepared on the cash receipts and disbursements basis, and, as a result, include as income 1968 membership dues of $110,322.50. Under generally accepted accounting principles, such dues would be deferred at December 31, 1967, and included in income during 1968. Accordingly, the statements as a whole, do not in our opinion present financial position and results of operations as they would appear had generally accepted accrual basis accounting principles been applied in their preparation.

In our opinion, the accompanying statement of assets at December 31, 1967, and the related statement of cash receipts and disbursements and the statement of operations for the year then ended present fairly the information set forth therein and have been prepared on a basis consistent with that of the preceding year.

Lybrand, Ross Bros. & Montgomery

Columbus, Ohio
March 29, 1968

OHIO STATE MEDICAL ASSOCIATION
Statement of Assets December 31, 1967

	Total	Executive Secretary's Account	Treasurer's Account	The Ohio State Medical Journal
Cash in bank and petty cash	$219,366.91	$197,186.41	$ 14,206.94	$ 7,973.56
Cash in savings accounts	82,727.16		82,727.16	
Certificates of deposit	30,000.00		30,000.00	
United States Government obligations, at cost	45,000.00		45,000.00	
Accounts receivable, advertisers, less allowance for doubtful accounts of $361.68	11,297.70			11,297.70
Deposit on postage	160.00			160.00
Office equipment, at cost less accumulated depreciation of $18,892.17	29,624.98			29,624.98
Deferred advertising income	(175.10)			(175.10)
	$418,001.65	$197,186.41	$171,934.10	$ 48,881.14

The accompanying note is an integral part of the financial statements.

OHIO STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year ended December 31, 1967

	Total	Executive Secretary's Account	Treasurer's Account
Cash in bank, beginning of year	$218,211.16	$176,256.95	$ 41,954.21
Cash receipts:			
1968 Membership dues	110,322.50	110,322.50	
1967 Membership dues	360,125.00	360,125.00	
AMA Dues refund	45.00		45.00
Interest on savings accounts and certificates of deposit	11,456.96	10,481.96	975.00
Interest on United States Government obligations	1,870.52		1,870.52
Rent	500.00		500.00
Exhibit space, 1967 annual meeting	17,140.00		17,140.00
Exhibit space, 1968 annual meeting	8,230.00		8,230.00
Annual Gaslight tickets	4,312.00		4,312.00
Fees for collection of AMA dues	5,576.67		5,576.67
Redemption of United States Government obligations	10,000.00		10,000.00
	529,578.65	480,929.46	48,649.19
Interaccount transfers (principally dues)		(460,000.00)	460,000.00
Cash disbursements:			
Ohio State Medical Journal	40,000.00		40,000.00
Salaries and expenses	137,602.81		137,602.81
Professional conferences and scientific meetings	70,521.84		70,521.84
Committee expenses	15,209.35		15,209.35
Department of Public Relations	46,781.18		46,781.18
Employees' benefits (Note)	26,789.22		26,789.22
Contributions	11,076.67		11,076.67
Contribution applicable to deferred compensation plans (Note)	75,000.00		75,000.00
General, including $10,000 investment in certificates of deposit	113,415.39		113,415.39
	536,396.46		536,396.46
Cash in bank, end of year	$211,393.35	$197,186.41	$ 14,206.94
Cash in savings accounts, beginning of year	$ 79,219.20		$ 79,219.20
Interest received	3,507.96		3,507.96
Cash in savings accounts, end of year	$ 82,727.16		$ 82,727.16

The accompanying note is an integral part of the financial statements.

Statement of Operations, Year ended December 31, 1967

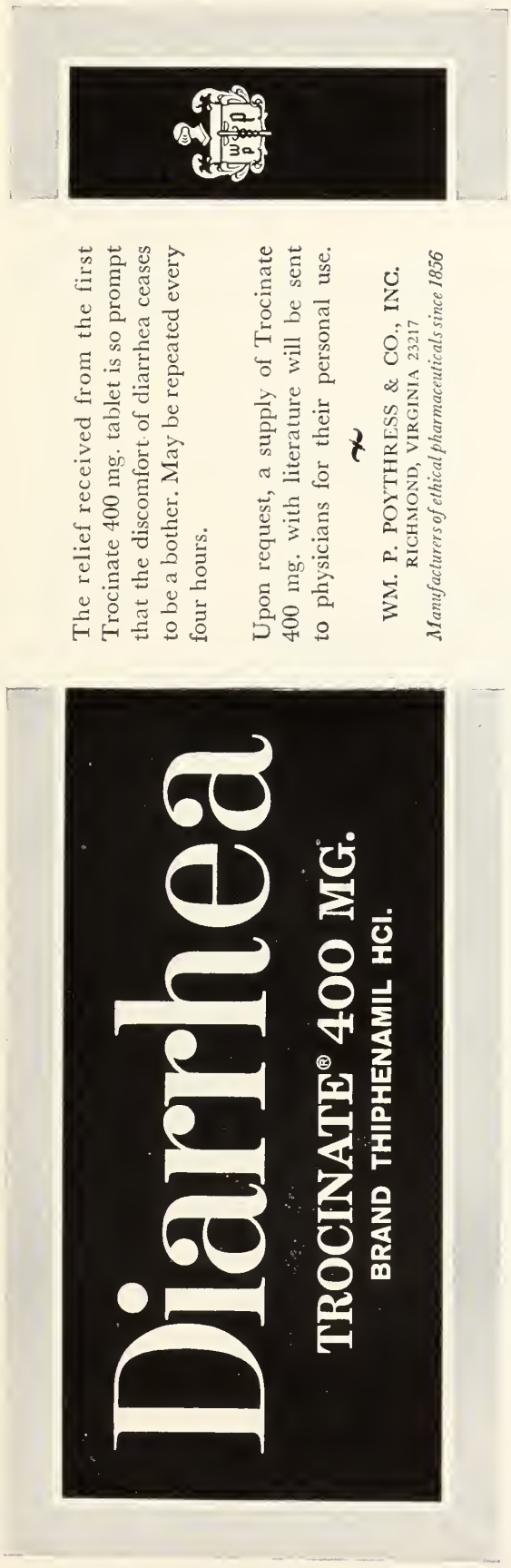
Income:		
Advertising		$101,994.89
Less:		
Commissions on advertising	$ 14,127.83	
Cash discount	908.73	15,036.56
Advertisting income, net		86,958.33
OSMA appropriation		40,000.00
Subscriptions		1,482.30
		128,440.63
Expenses:		
Salaries	34,905.00	
Journal printing	76,699.23	
Journal postage	1,754.75	
Stationery, printing, and supplies	4,435.71	
Illustrations and engravings	2,320.79	
Travel expense	96.57	
Depreciation	3,207.48	
Bad debts	361.68	
Miscellaneous postage	264.66	
Miscellaneous expense	75.00	124,120.87
Excess of income over expenses		$ 4,319.76

The accompanying note is an integral part of the financial statements.

NOTE TO THE FINANCIAL STATEMENTS

At December 31, 1967, the Association had deferred compensation plans covering three retired employees. Under terms of the trust agreement associated with such plans, the Association may transfer cash or other property in amounts deemed necessary or advisable in order to fulfill the terms of the plans. After such terms have been fulfilled, all remaining cash or assets held by the trustee revert back to the Association. As of December 31, 1967, the assets held by the trustee (approximately $136,000) exceeded the estimated liabilities of the plan. The contribution to the trustee as included in the accompanying statement of cash receipts and disbursements amounted to $75,000.00 for 1967.

In addition, the Association has a pension plan covering substantially all of its employees. Under the terms of the plan, life insurance policies sufficient to provide for future benefits are purchased annually by the pension trust. The contribution applicable to the plan and as included in the accompanying statement of cash receipts and disbursements amounted to $16,322.88 for 1967.



Summer Medical Careers Program Encourages Talented Students

A program designed to help young people decide on medical careers will have 38 participants this summer chosen from 34 colleges and universities in Pennsylvania and Ohio. The students were selected by their schools on the basis of outstanding academic backgrounds and suitability to the medical field.

The college men and women will take part in the Medical Careers Program of the Smith Kline & French Foundation, the scientific and educational trust of Smith Kline & French Laboratories, Philadelphia.

Students participating in the program work for eight to 12 weeks at one of the medical schools and receive stipends from funds made available to the schools by the S K & F.

Case Western Reserve University School of Medicine is the Ohio institution participating in the program. Students who will work there are the following: Barry H. Brooks, Jamestown, N. Y., Hiram College junior; Wayne Hostetler, Jr., Wooster, College of Wooster junior; N. Christine Kreger, Cincinnati, Denison University senior; Mildred Lam, Lexington, Ky., Oberlin College senior; Larry W. Neptune, Barnesville, Ohio Wesleyan University junior; and Roy M. Vigneulle, Cleveland, Baldwin Wallace College junior.

Ohio Psychiatry Association Officers Announced

Dr. Harold Hiatt, Cincinnati, became president of the Ohio Psychiatric Association during the recent annual meeting held in Columbus.

The new president called for a program of "aggressive helpfulness" in association with lay and political organizations.

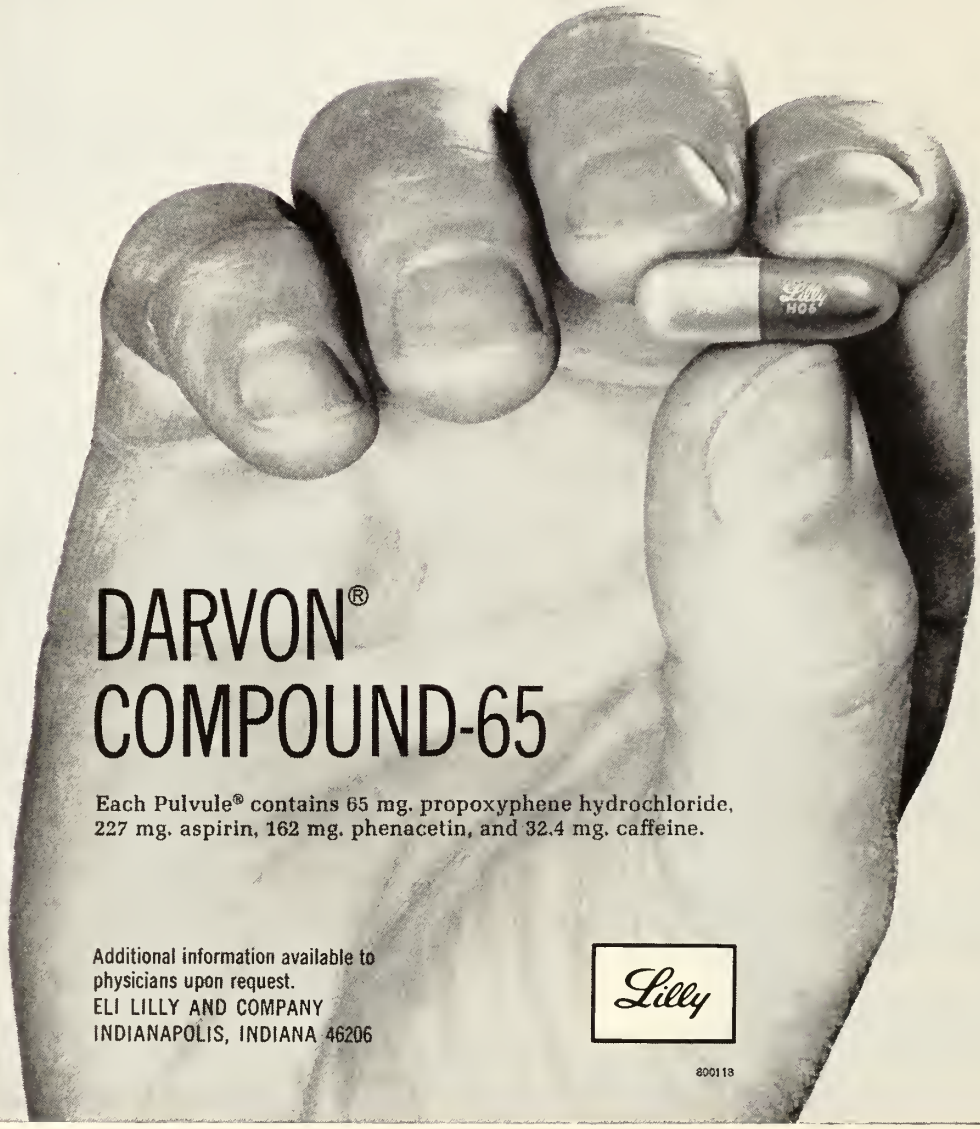
"We are trained to have some positive impact on the problems of individuals," he told the more than 400 members of the Association in a presidential message, "Is it possible we could transpose these talents to help a large group, namely the mentally ill of Ohio?"

Dr. Hiatt is chief of psychiatric service at the Cincinnati Veterans Administration Hospital and is associate professor of psychiatry in the Department of Psychiatry of the University of Cincinnati. He succeeds Dr. Victor Victoroff of Cleveland as president of OPA.

His recent publications include a study on "Guidelines for Community Mental Health Treatment and Research Programs," and "The Problem of Termination of Psychotherapy," published in the *American Journal of Psychotherapy*.

Other officers elected are: Dr. William Holloway, Akron, President-Elect; Dr. Milton Kramer, Cincinnati, Secretary; Dr. J. Patrick Duffy, Cleveland, Treasurer. The Association maintains offices at 88 East Broad Street, Columbus, Ohio 43215.

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COMPOUND-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to physicians upon request.
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OSMJ

Scientific Section

VOL. 64 AUGUST, 1968 NO. 8

Quackery and Sports*

KENNETH S. CLARKE, Ph.D.

IN THE 1940's, a supplier of athletic trainers' supplies and first aid preparations was reprimanded by the Federal Trade Commission (FTC) for excessive claims regarding germicidal efficacy, prevention of certain diseases, liniment powers, the energy qualities of their sugar tablets, and similar pseudomedical treatments.

In 1961, the Food and Drug Administration (FDA) seized another company's food supplement as a drug being falsely promoted to coaches as an aid to physical endurance, for preventing fatigue, lessening muscle soreness, and improving physical efficiency. Seized at the same time was another product by this company labeled to improve resistance to bruising, bleeding, and the common cold. The FDA charged that the product would not be effective for the conditions represented in the labeling.

More recently, the FTC ordered at least one manufacturer of a "swim-aid" device to stop using misleading advertising that inferred to the nonswimmer purchaser that the aid would allow him to swim immediately and without danger. In tests, the FTC found that the product actually kept the hips up but allowed the head to sink. At many beaches and pools, such flotation devices as the "swim-aid" are forbidden because they have led persons into false security, resulting in drownings.

You may think that I could go on *ad infinitum* in this regard by referring to an inventory of citations against sports quackery items. I cannot. A reasonable depth of search has provided only these three instances of direct governmental intervention in protecting the athlete from the sports quack. I could raise this figure to four if you would accept the action by another country against a U. S. - made product called Strawberry Ointment because it contained no strawberries.

I could raise the figure to five, if you would accept the FDA's action to withdraw dimethyl sulfoxide (DMSO) from its human trial status last year. The problem with DMSO was that popular publicity had jumped the gun on the evaluation of the drug in its preliminary testing stages. The resulting tremendous clamor for DMSO's purported sensational qualities caused problems for practitioners who (1) did not have the benefit of investigation reports that would define values and hazards associated with particular circumstances and patients; and (2) would not have been using the drug ethically or legally unless in a registered study for one of the several sponsoring drug companies. Yet even though the drug was still restricted only to authorized clinical investigations conducted by registered medical personnel, even though the drug had particular

The Author

● Dr. Clarke, Chicago, is Staff Coordinator, AMA Committee on the Medical Aspects of Sports.

*Presented at the Ohio State Medical Association Postgraduate Institute for Physicians on Athletic Injuries, August 17, 1967, Columbus, Ohio.

hazards in the athletic setting, this did not hinder some of the principals involved to extol the virtues of DMSO to coaches and trainers.

The Practitioner in Sports Medicine

Practitioners in sports medicine quickly find a heterogenous group of candidates for high school sports to work with. Because of the demand on these athletes for maximal performance and durability, because the evaluation of their coaches' qualities are at the scoreboard, and because any unusual "reason" for success is headlined uncritically, the impatient and insecure in the world of sports are not free from the temptation to try shortcuts, to dabble curiously and indiscriminately with virtually anything that is said to improve the athlete's performance or return to performance.

The result is widespread confusion. Acceptance of ineffective if not hazardous practices may occur; moreover, rejection of worthy practices may occur. For example, no one has said that DMSO will not eventually be a drug of value in the practitioner's repertoire of medicinal alternatives. But the indiscriminate and premature fanfare not only introduced a potent drug into the public's lifestream without knowledge of its effects, but it also has delayed, if the drug proves to be efficacious, its *proper* entry into the medical community. Likewise, the fanfare given isometrics five years ago was so overwhelmingly nonsense that one still must defend meticulously the selective use of isometrics within an overall conditioning program.

Another example may help illustrate another hazard from confusion. A locally well publicized investigation was perpetrated hotly in one Southern community this year by the administration of "super vitamins" to high school athletes. From the news articles, it appears that these had erroneously been thought by some to be "pep pills." Worse, the newspapers intimated from their interviews that the coaches, as a result of the sensational and emotional aspects of the probe, will be reluctant in the future to give salt pills during the practice sessions held in hot weather.

The Practitioners' Dilemma

When the practitioner applies his skills in the athletic setting he faces a vast number of problems that are not conveniently handled as was DMSO by the Food and Drug Administration. He is faced with a myriad of superstitions, traditions, pressures, and misconceptions that may confuse or run afoul of his concept of sound health care of the athlete. Yet he is faced with the need for decisions and actions of a scope, an accuracy, immediacy, significance, and publicity not experienced previously in his medical practice, nor anticipated in medical school. He is faced with guarding both against undue restriction of a well motivated patient population and also against overzealousness in his management of this same population. And he is faced with a host of experts to lead him in many directions. These problems, experts, decisions, and actions presuppose a physician whose degree of experience is matched by courage and discretion.

Because sports medicine has new and unique twists to the practice of medicine, his experts stand on professional judgment in the midst of a virtual void of meaningful statistics that would substantiate or refute their respective contentions. Most of these experts are legitimate national groups, competent local practitioners, and authoritative representatives of allied professions who know that a team physician must act according to some principles of good and bad and cannot await the convenience of statistical support. However, some of the experts are more sincere than competent and are experts merely because nature abhors a vacuum, whether the vacuum be a lack of competent involvement in a community's sports programs, or whether the vacuum be a lack of solutions to important problems in sports. And finally, some experts are experts only for the publicity and financial gain coming from the glamor or the guarantee they give to their offerings.

Nonetheless, the practitioner quickly finds that nothing is automatic in sports and medicine unless it be their parallel heritages that experts will differ in their opinion on matters of importance to practitioners.

Perhaps the following portion of a poem entitled "Little Herder in Spring, In Summer"[1] by Ann Clark helps in expressing this dilemma:

> For a long time
> there have been meetings
> of many men
> for many days.
>
> At the meetings
> there is talking,
> talking,
> talking,
>
> Some this way.
> Some that way.
>
> In the morning
> when my father
> leaves for meeting
> he says to us,
> "When I come here again
> then I will know
> if it is best
> to have many sheep
> or few sheep,
> to use the land
> or let it sleep."
>
> But
> when my father
> comes home from meeting
> he does not know
> which talking — way to follow.

I was very pleased to have been asked to relate the problem of quackery to your interest in sports

and your dilemma at times of determining which talk-way to follow. To capitalize on the unique advantage sports offers for medicine and education, the essential problem is more of relating sports to the tragedies of quackery than itemizing the quackery found in sports. An FDA official provided us with a functional concept of quackery when he told an AMA school health conference: "The word 'quackery' includes a wide variety of misinformation concerning health which misleads the public even though there may be no deliberate intent to mislead." Quackery thus serves as a vivid and forceful synonym for abuse based on folly. In sports, a shocker is needed to label such abuses for what they are. But equally important: If quackery is the *antithesis* of all that medicine stands for, we must be sure of our *thesis*. To use the word "quackery" requires standards and criteria that clarify the outer limits of *legitimate* controversy. Let's continue with the poem of the Sheepherder's dilemma:

Tonight
when my father
came home from meeting
he just sat, looking
and looking.

My mother gave him coffee
and bread and mutton,
but my father just sat,
looking.

Then my mother . . .
said,
"A meeting is like rain.

When there is little talk,
now and then,
here and there,
it is good.

It makes thoughts grow
as little rains make corn grow.

But big talk, too much,
is like a flood
taking things of long standing
before it."

Team physicians are aware that with the courtship of sports and medicine came a legacy of traditions that must be encountered. The challenge is to respect the colorful traditions of sports while bringing out in no-nonsense objective fashion that which will discriminate between desirable and undesirable (beneficial and nonbeneficial) manifestations of some of these traditions.

"Big talk" is the province of organizations and the authorities upon whom they rely for the stipulation of principles of sound practices for practitioners to adopt and the warning of known deleterious practices for practitioners not only to avoid but combat. It also is the avenue of the quacks. The payoff is the quality of the small talk — the actual communication between physician and physician, physician and coach, physician and athletic trainer, physician and athlete, physician and parent — in which judgment is translated to the reality of the particular occasion. This payoff has far more profound implications than avoiding quackery in the care of a team; it involves the education of a youth (and his leaders) during his most impressionable years on matters of lasting importance to his health.

In this regard, consider the inquiry received from a young lad who aspired to be an athlete but who feared he could not afford what he had been led to believe was nutritionally essential. Or the 14 year old boy who sent us an air mail special delivery letter asking how to add muscle to his arms and shoulders, decrease the flab from his waist and hips, and get more energy — while superimposing the words PLEASE HURRY throughout the plea. Is it surprising that even the young gain anxieties from misinformation that contribute to the quack? Consider the popular magazine article which leaned heavily on nonmedical personalities for opinions on the values and hazards of anabolic steroids in the quest for weight gain. Or the author in a scientific research journal who mentioned — in the related literature section of his paper on oxygen as an ergogenic aid — only those articles that agreed with his contention that there was a beneficial effect. Or the entrepreneur who, when the authorities caught up with his quacky automatic exercise device sales program, merely changed its name and city of operation and resumed business — five times to date.

Or the Fitness Committee programs of the American Chiropractic Association that now are using legitimately educated professionals and effective exercise machines in an attempt to boost the respectability of chiropractic. But chiropractic remains chiropractic; chiropractic theory remains untenable; chiropractic education standards remain a farce; chiropractic educational institutions remain unaccredited by all educational accrediting agencies; and chiropractic practitioners' quest for status remains central to programs which will make them appear respectable in their community. Lack of competition by the educated faction of that community "verifies" the respectability of chiropractic in the eyes of the uninformed public who may look at the medicine-chiropractic war merely as combats of professional jealousy. And what is more "respectable" now in our communities than taking an interest in sports and fitness for our youth?

Obviously, an athlete's health can be undesirably affected by far more than is legally stipulated and enforceable by federal statutes or than is scientifically indictable by research. An unwarranted promotion, an unworthy device, an indefensible practice can be perpetuated unwittingly by a competent and sincere practitioner as much as by a cultist or out-and-out criminal fraud. More simply stated, it is the promotion more than the product of which the buyer must beware.

That "big talk" can't combat each individual promotion is expressed by the old story about the

three umpires discussing their competencies in calling balls and strikes. The first umpire declared: "I call them as I see them." The second retorted: "I call them as they are." The third closed the conversation by confirming: "They ain't nothing until I call them."

The task thus is to reduce the "big talk" about the benefits and hazards of sports to a perspective that relates sports performance to health, helps interpret promotions in the context of the needs and aspirations of each athlete, and provides a collective platform for firm and bold small talk against crass abuses in the health care of the athlete.

Sports and Health — A Perspective

1. Sports have educational and health values. If not, sports would have no business being conducted in our school's programs. The risks within sports would be encountered only to permit a catharsis for selected aggressive young men for the entertainment of others, and the experiences would merely be as a placebo rather than a positive boost to maturity.

There are entertainment values as well, a realization not lost to business oriented factions; and there are abuses in the entertainment aspects, a fact not lost to others. But the virtues in sports can live in harmony with business, *providing* that decisions are not based on the virtues of performance or entertainment to the exclusion of the health and educational qualities that justify and perpetuate sports in our schools and communities.

2. Paralleling the purposes of athletics and thus the goals of the athlete is the modern concept of health: not merely the absence of illness or injury but the quality of development and utilization of one's natural resources. Consequently, and especially because of the preventive medicine aspect of a high level of health and fitness, there is emerging in medicine a new concept of "normal" geared to the trained motivated athlete. For example, the old but still prevalent notion that the athlete's heart is a pathologically enlarged heart has been exploded as a myth through the medical involvement in sports. The true athlete's heart — the efficient heart of the trained athlete — is now considered normal and its counterpart — the loafer's heart — abnormal.

3. The training program brings conscious attention to and personal respect for many components of personal and public health within a context allied with the athlete's interests and understandings. The young boy who achieves an athlete's heart has only a remote latent interest in the eventual hazard of atherosclerotic disease; his immediate interests of conditioning offer a far more meaningful application of dictum into practice. To the same youth, a cigarette's threat to athletic fitness is far more meaningful during his habit-forming years than the threat of chronic disease. His concept of his future simply doesn't extend that far.

4. The game and the training program play complementary roles in the pursuit of excellence. The training program necessary for effective participation in sports relates far more to the health, fitness, and safety of the athlete than participation in the game itself. The game provides the cultural prestige, the peer admiration, the motivation, and the fun necessary to capture and absorb active youth for the adventurous self-testing experiences they seek and for the self-discipline it takes to adhere to the desired training program.

5. To achieve the benefits of sports, the element of risk must be encountered. The result is the ever present equation of calculated risk (benefits over risk) that must be the basis of every supervisory decision in sports. Without risk, sports would lose its motivational appeal for youth; and without appeal, youth would not obtain the educational and physiological values from responding favorably to the stresses of training and participation.

We are not against risk, we are against jeopardy. The calculated risk equation is not amenable to computerization, but we can appreciate that jeopardy exists if to the denominator we add undue risk or from the numerator we void some of the beneficial outcomes.

6. If sound health practices protect the athlete from unnecessary hazards, and the health and educational qualities of sports justify the calculated risks taken, any promotion of misinformation that detracts from the desired goals in this regard relates to the problem of quackery and sports.

For example, sports benefits do not occur automatically. If an athlete is led to believe or leads others to believe that what causes success is in fact a gimmick rather than talent, genetics, hard work, confidence, and healthful living, the numerator is lessened and the risks taken with less justification. Conversely, sports injuries likewise occur, and likewise not automatically. Periodic evaluation of supervisory decisions and actions is necessary to define the causes of occurring injuries and to determine improved preventive measures for the eradication of these occurrences. The term "eradication" is not realistic but philosophical. It does not imply that all injuries are results of negligence, incompetency, or quackery. But it does underly the justification of physicians encouraging suitable participation in sports and becoming irate when abuses clearly exist.

Abuses

With such a perspective, what practices are there at this moment that can be related to quackery as out-and-out abuses?

Three come to mind immediately: spearing, doping, and dehydration. All can be condemned as indefensible by physician, physiologist, and any ethical person.

Spearing is the tactic of intentionally sticking the helmeted head into the opponent for assorted purposes including blocking and tackling. It was initiated because the helmet was thought sufficient armor to protect the head and because it was thought to check effectively the forward progress of the opponent. It has also been used to punish the opponent after he had been slowed, even after he had been downed. As this tactic was defined as being used, the statistical fatality reports began to show a 95 per cent proportion of deaths directly attributed to football being of the head and neck, and as neurosurgical investigations began to verify, the act of teaching spearing became an irresponsible, totally indefensible, sadistic act.

"Big talk" has been going out since 1962 on the mechanics of why the head and especially the neck are extremely vulnerable to this tactic. It remains for the small talk in certain locales to be equally emphatic.

Doping has been curbed quite well in the United States in the past decade; the sports pages are even helping in the condemnation of the use of stimulants and vasolidators. There still is a pharmacological debate on what are the performance advantages *if any* of doping an athlete, but the clinical, physiological, and ethical feelings remain firm: *there is no defense for the use of drugs in the attempt to boost the athlete's chances.* The not infrequent reports of deaths in Europe from this cause, however, give cause for maintaining a vigilance, especially for the sake of upcoming young athletes who may have escaped the big and small talk on doping of the 1950's and early 1960's.

Several nondrug approaches flirt with medical prerogatives such as oxygen, hypnotism, and other gimmicks which take their turns in testimonials to athletic success. The facts remain that gimmicks by definition* are of no more help to success than the odorous practice of never changing underwear during a winning streak.

Dehydration is another matter. Of all the practices in all the sports that can unequivocally be categorized undesirable or hazardous, voluntary dehydration is by far at the top in frequency and entrenchment. The arbitrariness of a few pounds goes a long way in sports. We read of a player who faces a penalty by a football coach by showing up several pounds over a magic number; therefore, to the rubberized suit or hot box he goes to get a quick pat on the back instead of punishment. A professional boxer weighs in for a bout two pounds over and the official gives him two hours to make weight; the boxer legally qualifies after literally sweating it out. Jockeys play the weight numbers game as well.

By no means should dehydration be considered a form of weight control—by coaches, by athletes, by officials, or by the press. It is only the temporary loss of H_2O, not F-A-T. Water is a nutrient, the body's most necessary nutrient. Water deficiency takes its toll quicker than deficiency of any other nutrient. Sudden loss of just 3 per cent body weight—which has to be water to be lost suddenly—can impair performance. If just the undesirable performance impairment threat can be the small talk's focus, the serious problems from extensive dehydration will never be approached. In fact, at least three studies have appeared in which the engorgement of water prior to a heavy workout has increased performance endurance levels—the only ethical form of physiological supercharging I know of. Yet we read of deaths or near deaths from young boys using rubberized suits to get in shape, and from the withholding of water from players during hot humid football practices. I even have documentation of clinical heat exhaustion in a wrestling room in which the temperature and humidity were purposely high to permit greater weight loss of the candidates.

It would be one thing to speak of the sensational death or near-death. But a huge number of athletes stand behind them who are injured while in a state of heat fatigue or who jeopardize their performance levels—actually "run out of gas"—by the folly of intentionally altering their fluid balance.

Medical treatment is highly specific and beyond the scope of this paper. According to one article, there are 32 factors that can significantly alter drug behavior in the body, and I sympathize with any physician who must decide what drug, when, and how much.

I can appeal, however, against the use of drugs or therapeutic devices where there is no clinical justification for such use. The customary criteria for "good medicine" still apply; the athlete needs no more in his quest for high performance. For example, to inject painkiller about a joint for the return of an injured athlete is not treatment and does him no service.

Another example is the current interest in anabolic steroids which, while not doping, has crept into the criteria for quackery in sports. Its users are getting small talk that the steroids are merely weight gain pills and are accepting serious risks to no advantage. Anabolic steroids have been shown to be ineffective for increasing performance levels. Physicians familiar with these potent drugs respect their hazards even when given under clinically justified conditions. Yet

*A gimmick, whether innocuous or hazardous, is an ineffective practice or device which is misrepresented to the athlete to improve performance. A practice or device competently used to motivate (not fool) an athlete is not a gimmick but rather one of the colorful traditions that keep sports an interesting challenge.

clinically normal males are taking dosages that exceed in amount and length those given for justified cases. Through the athletic grapevine the users include adolescents and, worse yet, preadolescents who face additional hazards, including stunted growth.

Not many problems can be so aggressively discussed. Selection of equipment, training technics, use of modalities, care of certain injuries, etc., is determined at a given time for a given reason with basic criteria sufficiently discussed in the literature. Nonetheless, a well-studied background of all essential principles relevant to questionable promotions can be of help. Let me use nutrition to illustrate.

Nutrition does not produce performance, it helps sustain it. Any promotion that implies improved performance from a dietary aid is misleading. This assumes of course that there is no medical diagnosis of nutritional deficiency to overcome, a most unusual diagnosis in the athletic population.

The concept to be kept in mind is that the body responds as a whole to meeting energy requirements. Assuming we are not talking about sprint events, prolonged energy needs must be accommodated by the body's stores.

The high energy phosphate molecule is the fundamental source of energy, regardless of what food delivers it. Glycogen is a ready reservoir for the phosphate molecule. Muscles contain only a small amount of available glycogen. Therefore, the liver stores of glycogen must be relied upon during activity. But there is a limit to the capacity of the liver to store glycogen prior to an endurance event.

The next resource for energy purposes is the fat stores; in fact, cardiac muscle depends primarily on fatty acids instead of glucose for fuel. The well-trained athlete has a fat depot of only about 7 to 10 per cent body weight. More may impair performance; less may be insufficient for sustaining protracted activity. But it can be seen that energy for endurance activity may rely a good measure on fatty acids, and that the concept of energy stores or reserves becomes more meaningful in discouraging heavy work output within a day of all-out effort than in encouraging undue dietary changes at the expense of other nutritional considerations for supporting activity.

The direct connection of diet to fuel, therefore, is a frustrating and inadequate approach to sustaining the athlete. What remains is instilling confidence that what is appetizing to the athlete is best, assuming he receives sufficient calories from a balanced diet as typically recommended and as averaged over a period of time to match his energy output. For most athletes, variation in true skill will mask any possible effects of nutritional variation. The physiopsychologic reaction to the emotions accompanying competition has implication for timing pregame meals, but the stores will not be affected if previously well stocked.

Defenses Against Sports Quackery

With such a perspective, what defenses can be offered to protect sports and athletes against the quack?

1. First and foremost is *physician involvement* in the sports program. The war against quackery will be won by competition not confrontation.

Only in recent years has the wedding of sports and medicine been formalized, consummated, and found compatible. Physicians have been active as athletes and as medical counselors to athletes since the beginning of athletics. But until the 1950's, there was no organized approach on the part of medical associations or societies to the problems of medicine in athletics. As a result, the fruits of the marriage are still forthcoming, but they are now considered "legitimate" and of a stock that measures up to the highest ideals in the heritages of both sports and medicine.

As is evidenced by this gathering, no longer is the physician suspect who lends a professional hand to those who engage in athletic contests. His athletes now appreciate that these hands are not the insensitive hands of disqualification. His colleagues now appreciate that the offering of the hands constitutes acceptance of unique and exacting responsibilities.

But of even more significance, medicine and education are coming to respect that there are more than injury patching benefits from applying the art and science of medicine in the athletic setting. Sports participation is often the first opportunity for youth to experience a positive functional personal association with a physician. These experiences leave a vivid and lasting impression with the sports participant.

2. The defense of next greatest significance is the support of professional education standards for, and established by, coaches and athletic trainers. Most of the concepts of healthful living can be found in the athletic setting. Regardless of the competency of the involved physician, the small talk of the coach and athletic trainer are potent in the education and handling of the athlete. It is no small coincidence that, in this era of the advent of the team physician as a distinct entity, the American Medical Association has seen fit by House of Delegate action to honor the athletic trainer as a professional ally and to urge all physicians to assist the programs of the National Athletic Trainers Association.

It is also significant that the recent major "big talk" releases from the AMA Committee on the Medical Aspects of Sports and similar committees at state and local levels have been oriented to the coach as much as the physician. Coaches at the high school level too often do not have the benefits of

physician and athletic trainer supervision for decisions on health matters. Further, respected coaches who speak at coaching clinics are in an advantageous position not only to teach defensible tactics, but also to make it explicit that hard-nose coaching does not include indefensible tactics.

They will have an index of suspicion that arouses skepticism concerning unusual claims made for health products and practices. They will be sensitive to the waste of time and possible harm that can result from self-diagnosis and self-medication. They will help acquaint their peers with the educational backgrounds and qualifications of persons who provide health services. They will look to reliable sources of health information when questions arise.

4. Transcending all lines of defense is research. Research is an ever ready nomination to a list for attacks on ignorance. However, more important is the interpretation of research. The laboratory can never fully duplicate the athletic scene for research purposes. Therefore, the pivotal person in the development of meaningful statistics is the practitioner. It is he whose professional eyes observe athletes under field conditions, and it is he who must retrieve from the stores of knowledge the meaning of his and others' observations when a decision is required.

Of importance in the interpretations of others' reports is consideration of (1) the contentions underlying the choice of design; (2) the criteria for judging the significance of the results; (3) the limits of applicability of the results; and (4) the influence on the results of untested, uncontrolled, and unacknowledged factors. In use of research, the context of the particular athletic problem must be considered central and the philosophy of sport considered sacred. Of least importance is the author's conclusions.

5. The final and most difficult defense is the promotion of standards for judging promotions. The quest for ever better fitness, treatment regimens, and skills defy standards that predetermine how much more a person can get skilled, fit, or well, or how much quicker could be the process.

The pragmatic approach is to return to the umpire who said "They ain't nothing until I call them." For this, the categories of *helpful, unnecessary, undesirable,* and *hazardous* seem advantageous. An athlete who is well versed in the principles of athletic training would find it rather easy to differentiate a promotion one from the other by asking the dual question: "Would it be helpful in my case?" and "Would it be hazardous in my case?"

If "yes" to both, the concern is too profound for him to answer, he knows he has a team physician to turn to. If "yes" to "helpful" and "no" to hazardous, he has another option for his choice of options. If "no" to both, the verdict is either unnecessary or undesirable, in other words a gimmick. His respect for the ethics of amateur athletics and the physiology of exercise would assist for distinguishing between the unnecessary and the undesirable.

It would seem logical that all commercial advertisers relating to athletics, if they are interested in the purposes of sports, would abide by a similar voluntary code of categorization. There is no reason to misrepresent a product if it is helpful in some respect, and there is no excuse for marketing it if it isn't helpful in any respect. Further, the supervisory staff should likewise take the pledge. What they want is to make each candidate the best possible athlete. It seems illogical to assume that their small talk could be dedicated to anything but this goal.

Comment

Quackery is not the sole province of black-hatted mustached sinister frauds who practice medicine on ignorant unfortunates, surefire cancer or arthritic cures being sold to middle-aged and elderly people, wild claims of old-time hucksters to be laughed at by our sophisticated teenagers, or bust developers and hip reducers being sold by fitness hotshots who play both ends against the middle.

Throughout history, the quack has been modern, parodying the medical uncertainties of the times. Only now, with the emphasis on prevention of organic disease via conscious fitness efforts by respectable people, and with our increased leisure time that both brought on the need for a conscious fitness effort and gives us the time to become apprehensive about it, the quack has even a greater advantage. He has been given a wider scope to operate, his operations a lot more respectability than ever before, and his promotions a lot of help from sports. For bad and good, our society is coached to follow the lead of the star athlete in the path to fitness and success.

Consider the following words on athletic knee injuries printed in a book[2] by a chiropractor that is now being promoted widely among chiropractors:

> "Caring for athletes generally, is excellent public relations since so many people are strongly interested in their local players. Injuries and recoveries are all publicized along with the name of the doctor, and a doctor's good record of keeping players in the game will soon be well known by an entire community. It is especially helpful to the chiropractor seeking a foothold in a new practice when his name is mentioned repeatedly as 'Dr. Doe,' the chiropractor who kept a star player in the game. The usual crowd, teen-agers and adults, who discuss athletics at the corner drug store over sodas and coffee, soon let their parents and friends know of this fact. The parents and friends in turn will go to the doctor because they 'heard so much about him'—and Dr. Doe will soon have a practice."

and:

> "Do not become discouraged if the first (ad-

justment) attempt on a knee does not work at once. Think back to the ineptness we showed the first time we attempted to adjust an atlas. It takes a bit of perseverance."

The tragedy of quackery is when misinformation on health matters erodes the athlete's chances for a successful competitive experience, today and in later life. This occurs when:

(1) The athlete is bilked out of the level of performance of which he is capable.

(2) The athlete is duped into relying on or crediting his satisfaction and success to things other than the development of his natural reserves.

(3) The seemingly innocuous forms of gimmickry are taken to extremes or taken to the exclusion of necessary healthful training practices.

(4) The duped athlete turns from the unnecessary or undesirable to the hazardous practices such as pep pills, anabolic steroids, or unqualified practitioners.

(5) The already strained budget, school or personal, is further burdened with items that are not helpful for safe, effective, and healthful participation in sports.

Obviously, antiquackery efforts are not simply vendettas against antimedicine persons.

We talked of defenses, but the best offense against sports quackery is an economic attitude. By economic is meant confidence in competence, adroit selection from the misrepresented, and active avoidance of the indefensible, the unqualified, and the hazardous. The athlete cannot "afford" to rely on unsound advice on matters of importance to his desire for athletic readiness. The law of atrophy from disuse must be applied to unwarranted promotions as well as muscles.

Such an attitude requires a respect for acceptable concepts and qualified professionals. It also requires the cautious uncertainty and scientific open-mindedness that permits a scrutiny of new ideas advanced on their merit, not on their promotion. It also can be strengthened by an emotional commitment to sound principles achieved through the laboratory of experience in the athletic setting.

• In a state in which one accident insurance benefit plan covers all school sports programs in that state, the chiropractics recently sought eligibility in the plan as practitioners. They were given their due hearing at which time the state's school sports administrator, who had been an athlete, physical educator, and coach, inquired as to the nature of their management of knee injuries. The response given him precluded for him any need for medical "big talk" on the educational inadequacies and cultism of chiropractic. He found out for himself. His knowledge of anatomy, kinesiology, physiology, and research methods staple items in the physical education curriculum and his disrespect for folly in the care of athletes gave him the defenses commensurate with this situation. The chiropractors were turned down.

• An athletic trainer of a professional football club, former athlete and now a physical therapist, phoned long distance when he heard we had a statement explaining the incongruousness of anabolic steroids administered to healthy males. He was grateful for such help in showing curious athletes, coaches, and athletic trainers in his acquaintance the folly of such interest.

These illustrations show the help in small talk that medicine gets from educated men devoted to and part of the proper supervision of sports.

These actions also illustrate the following quotation: "Quackery does not die easily. Exposures of the frauds perpetrated by the quack and nostrum vender do good only to the extent that such exposures educate the public. When the veil of mystery is torn from the medical faker, the naked sordidness and inherent worthlessness that remain suffice to make quackery its own condemnation."

These words were printed in 1912 in AMA's book on *Nostrums and Quackery.*

It's not so much who is the sports quack as it is who in sports is contributing to the quack. The true test of a sports experience may just be whether or not the athlete can strip the veil of mystery from quackery. One can only wonder how many athletes who labor under misconceptions, either from gimmick promotion or from a void of positive education, move from an unnecessary but innocuous practice to one that is unnecessary and harmful. The vast amount of quackery being aided and abetted by many of our adult population gives indirect evidence to the need for this concern.

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Physical Training Technics

GLENN V. SWENGROS*

THE FORCE that directs individuals to attain high levels of physical fitness varies with everyone. An eminent physician once told me that there were really only two times in a person's life when physical fitness was a primary concern. The first was when the individual was young and had an interest in participating in sports and the second was when, as an adult, a physical disorder made it apparent that good health was not to be taken for granted.

Physical Fitness

Physical conditioning programs have gained continuously in their importance in the scope of athletic programs. Throughout the history of sports development, innumerable facts and fallacies have emerged. Many of the fallacies are being disproved, exposed, and eradicated. No longer do we tell football players not to swim because "it builds the wrong kinds of muscles." Baseball pitchers are no longer told to refrain from lifting weights because "they will make you muscle bound." Instead, we explain the values of off-season conditioning programs and give instructions in their proper use. Continuing research is giving us better information on the physiological effects of exercise, and improved training programs are demonstrating that this information can increase athletic performance and reduce injury.

Three basic components of fitness most frequently associated with athletic performance are muscular strength, muscular endurance, and cardiovascular endurance. The *strength* component can be defined as the maximum amount of force that can be exerted during the single contraction of a muscle. *Muscular endurance* is measured by the length of time a muscle group can perform a specific task, and *cardiovascular endurance* is dependent upon the effectiveness of the heart and blood vessels.

Muscular strength is best improved through gradually increasing progressive work with resistive type exercises. Weight training is an excellent example and has increased rapidly in athletic programs at all levels. The specific measurement of the amount of work performed makes it relatively easy to measure the strength gains that are made and to tailor a program to fit individual athletes. The value of the use of isometrics as a means to increase strength has resulted in contradictory statements. However, some researchers have found as much as a five per cent increase per week in the daily use of six second contractions for specific muscle groups. Other researchers have indicated higher improvement in subjects using isotonic exercises as compared to the same number of subjects performing maximal isometric contractions.

Muscular endurance is developed through the continual training of muscle groups in submaximal activity. The high repetitious performance of calisthenics and light barbell and wall pulley weights proves effective for these purposes.

Cardiovascular endurance is best achieved through the use of submaximal effort carried over a long enough period of time. Typical forms of exercise involve the locomotor activities of running, swimming, rope jumping, rowing, and wall pulley work. The improvement in cardiovascular endurance occurs most rapidly in programs that involve progressive increases in the amount of activity completed during training sessions.

Conditioning Programs

It has become generally accepted that year-long conditioning programs are essential to maximum athletic performance. The team that fields the "superior" conditioned athletes has a marked advantage. We have reached a period in sports participation when the athlete who has waited to "play" himself into condition simply isn't good enough. Neither can he wait until "formal" practice begins to initiate his conditioning programs. Therefore, it is important that athletes understand the principles of exercise to give them the personal motivation necessary to continue conditioning programs between seasons.

School programs of physical education are improving steadily. Increased time allotments and improved instruction are developing both the student and his understanding of physical fitness.

The LaSierra Program

The physical education program of LaSierra High School in Carmichael, California, is one example of the degree of physical development that can be

*Mr. Swengros is President of Fitness, Inc., Washington, D. C., and former Director of Program Development, The President's Council on Physical Fitness.

achieved through school programs. Using a system of ability grouping, students who attain various levels of fitness competency are identified by the use of a color code. As a young man improves in the performance of various test batteries, he advances in the color code. The status associated with the higher color is equal to that of earning a varsity letter.

The conditioning phase of the program is developed on an athletic concept — that is, each member of the physical education class is treated as if he were a member of a varsity athletic team. He receives a great amount of personal "coaching" and is awarded for his accomplishment in physical performance by his promotion to a higher team (color group).

Editor's Note: It should be noted that the author presents the LaSierra program as "one example of the degree of physical development that can be achieved through school programs." A member of the OSMA Committee on School Health warns that a program of this magnitude should be undertaken only after a lengthy build-up program and then only under the closest of supervision.

The motivation afforded by this particular program is preceded only by the physical development of the participants. For example, to achieve navy blue status in the LaSierra program, the following goals must be met: 150 push-ups; man lift and carry 5 miles (carry a man within 10 lbs. of your weight on your back for 5 miles in any position); 50 bar-dips (parallel bar); 32 pull-ups (horizontal bar); 26 1-arm burpees (alternate) 30 seconds; 120 yard dodge run, 24 seconds; 300 yard shuttle run, 46 seconds; rope climb — 20 feet — 2 complete trips; agility run, 17 seconds; 100 extension press-ups — 8 inches; vertical pegboard, 5 trips; handstand, 45 seconds; mile run, 5 min. 15 sec.; five mile jog, finish; obstacle course, complete; swim — front prone position — 1 mile; swim — underwater — 50 yards; swim — any combination strokes — 2 miles; execute front hanging float with arms and ankles tied — deep water — 6 minutes; stay afloat in deep water in vertical position — use of arms and legs permitted within 8 foot circle — 2 hours.

One could not talk of conditioning programs for very long without mentioning the work of Dr. Thomas K. Cureton, Director of the Physical Fitness Research Laboratory at the University of Illinois. Dr. Cureton has done extensive work in both the adult and youth fitness fields. His experience in endurance training has led to the development of the continuous rhythmical exercise routine. Lasting for various lengths of time (but never less than 30 minutes), this system involves the principles of warm-up, stress, and tapering off exercises.

In this continuous, non-stop exercise routine, emphasis is given to the principle of interval training. The participant is alternately taken through periods of muscular and cardiovascular stress, and then eased off with lighter work. Dr. Cureton prefers a minimum of 60 minutes of work in this technique. Within the same time limit, he chooses from three different types of workouts, i.e., low gear (easy), middle gear (moderately hard), and high gear (hard). At least 20 minutes are given to the warm-up and approximately ten minutes devoted to the recuperative work — depending upon the severity of the workout.

Circuit Training

Circuit training is another conditioning technic that is increasing in popularity. In this program, a series of exercise stations are set up along a course. Usually 10 to 12 stations make up a circuit. The stations are usually selected with some particular sport or fitness component in mind. A typical circuit for a football squad might contain the following stations: stadium step running; blocking sleds; wind sprints; weight training; tackling dummy, etc. Three variables — time, repetitions, and resistance — are involved in designing a circuit. It is common to have varying degrees of difficulty within the same circuit, e.g., different barbell weights, increased number of sprints or trips up and down the stadium steps, etc. These options provide appropriate workouts for all squad members — regardless of ability.

It is also possible to develop a circuit for particular specialities within a sport. For example, some of the components involved in football quarterbacking are grip strength, arm strength (passing), passing accuracy, agility and speed. A single player is evaluated by actual testing in these components and a circuit is designed especially for him. A time limit is then established for a prescribed number of trips through the circuit. After a specified number of workouts has been completed the testing process is repeated and the goals for the individual stations adjusted.

Another program that is gaining in popularity is group weight training. Through the use of three-men squads, it is possible to develop training programs that keep all men occupied at the same time. While the Number 1 man of a squad is lifting, the Number 2 and Number 3 men perform cardiovascular exercises. Then, while the Number 2 man lifts, Num-1 and Number 3 perform cardiovascular exercises, etc. After all members of a squad complete one station they move, on command, to the next station.

Using this plan, 48 men can complete a weight training circuit that includes eight different exercises. The approximate time required for each man to perform the eight different lifts and the accompanying cardiovascular exercises is 21 minutes.

Summary

In the final analysis, a training program can only be as effective as the amount of time and dedication given by each athlete. Research in the fitness field

has resulted in the enlightment of physical education teachers and coaches. The continual communication between scientist, coach, and player will vastly improve technics in performance and conditioning. Longer and longer periods of time will be spent in preparation for each athletic contest. Since regulations specify the starting date of most supervised team practice, the athlete has to devote more of his own time to conditioning programs, thereby giving more actual team practice time to the mastery of individual and team skills. This will result in still greater accomplishments in the individual and team performances and—maybe even more important—the knowledge of physical conditioning technics will linger with the athlete as a way of life. If this occurs, our country will grow stronger and healthier and will not be defeated by the narcotic of luxurious living and its resultant drain on the vigorous life.

RELIEF OF ANGINA PECTORIS. — Carotid-sinus massage can relieve angina pectoris and has been used as a diagnostic test for angina. Stimulation of the carotid sinuses abolishes angina by lowering the three most important determinants of the heart's energy needs: ventricular pressure; heart rate; and myocardial contractility. Accordingly, it was considered that electrical stimulation of the carotid-sinus nerves might be of clinical value in the treatment of angina pectoris. Two men, fifty-one and fifty-four years old, with well documented myocardial infarctions in the past, and severe incapacitating angina pectoris, had bipolar platinum electrodes attached to their carotid-sinus nerves, which were connected to a radiofrequency receiving unit placed subcutaneously that could be activated by the patients on demand by a radiofrequency transmitter. In both patients stimulation of the nerves lowered arterial pressure and heart rate. All anginal episodes could be abolished immediately by activation of the stimulator, and prophylactic activation allowed the patients to engage in activities that otherwise were consistently associated with severe pain. Also, stimulation allowed a fifteenfold prolongation of the duration with which both patients could pedal a bicycle ergometer and increased significantly the level of work that could be tolerated before angina occurred.

The operation is relatively simple, the instrumentation is commercially available, and the results of the first two patients are encouraging enough to warrant cautious trial in a larger number of patients with coronary artery disease and severe, incapacitating angina pectoris. — Eugene Braunwald, M. D., et al, Bethesda, Maryland: *The New England Journal of Medicine,* 277-1278-1283, December 14, 1967.

Multiple Myeloma and Miliary Tuberculosis

Case Report

N. V. DIMITROV, M.D., L. G. SUHRLAND, M.D., and W. B. CHAMBERLIN, Jr., M.D.

PATIENTS with multiple myeloma have increased susceptibility to bacterial infection and have a defect in ability to form antibodies.[1-6] Although pulmonary tuberculosis has been encountered in combination with multiple myeloma,[7] a survey of the literature failed to reveal any reported case of acute miliary tuberculosis associated with multiple myeloma. Therefore, the following case is presented to illustrate an unusual combination of multiple myeloma with acute miliary tuberculosis.

Case Report

An 85-year-old Negro woman was admitted to another hospital in December 1964, with the diagnosis of bronchopneumonia. The patient had been febrile about one week prior to admission, but symptoms of cough, dyspnea, sputum production, and pleuritic pain were absent. On physical examination, she appeared to be somewhat disoriented with a temperature of 37.8°C, pulse rate 88 per minute, blood pressure 115/70, and respiratory rate 20 per minute. Rales were audible at the left lung base.

Hemoglobin was 11.5 Gm/100 ml; hematocrit 33 per cent, WBC 6,000 with a slight shift to the left; platelets 286,000; and indices were mean corpuscular volume 95, mean corpuscular hemoglobin 32, mean corpuscular hemoglobin concentration 34. Serum electrolytes were within normal limits. BUN was 50 Mg.; creatinine 1.2 Mg.; calcium 8.5 Mg. total protein 9.0 Gm. with albumin 1.6 Gm. and globulin 7.4 Gm. per 100 Ml. Serology was nonreactive, and blood cultures showed no growth. Sputum culture yielded *alpha Streptococcus* and *Staphylococcus aureus* (untypeable). Intermediate and second strength PPD skin tests were negative. Chest film revealed marked cardiac enlargement and low grade, diffuse pneumonitis. Skull films were normal, as was an upper G. I. series. Electrocardiogram showed left ventricular hypertrophy with septal wall myocardial ischemia.

Submitted January 4, 1968.

The Authors

- Dr. Dimitrov, Philadelphia, is Assistant Professor of Medicine, Hahnemann Medical College, Philadelphia.
- Dr. Suhrland, Cleveland, is Associate Professor of Medicine, Case Western Reserve University; Associate Director of Medicine, Highland View Hospital; Assistant Physician, University Hospitals; and Associate Physician, Benjamin Rose Hospital.
- Dr. Chamberlin, Cleveland, is Assistant Professor of Pathology, Case Western Reserve University, and Director, Department of Anatomical Pathology, Highland View Hospital.

Treatment with tetracycline was started, the patient's low grade fever, never above 100.4F°, (38°C) gradually subsided over the first week, and she remained afebrile. On the fifth hospital day, the patient was found to be coughing or sneezing up blood. Examination revealed blood coming from between the vocal chords. No lesion was found, and investigation of her clotting mechanism failed to yield an adequate explanation. Hemotocrit fell to 17, and the patient was given 3 units of whole blood. Serum electrophoresis demonstrated a peak in the gamma globulins (55.5 per cent of total area), and immunoelectrophoresis showed a monoclonal protein of the gamma globin variety with relatively fast mobility (Fig. 1). Urine test for Bence Jones protein was negative. Bone marrow smear revealed "cellular marrow mostly replaced with clusters of plasma cells, many atypical, consistent with multiple myeloma."

The patient was transferred to Highland View Hospital, Cleveland, for further treatment in January 1965. On this admission she complained of some pains localized in the knees, which had been present for many years. She denied any episodes of bleeding or any other pains. On physical examination, the pa-

tient appeared to be in no acute distress. Blood pressure was 110/50, pulse rate 76 per minute, and temperature 99.8° F (37.7°C). The lungs were clear. The abdomen was soft, without tenderness, and liver spleen were not palpable. A bone survey showed slight demineralization not inconsistent with diagnosis of multiple myeloma.

Hemoglobin was 8.5 Gm per 100 Ml., hematocrit 26.5 per cent, RBC 2,650,000, and WBC 3,300 per cu. mm. with 82 per cent neutrophils, including 3 bands, 15 per cent lymphocytes, and 3 per cent monocytes. Platelet count was 249,000 per cu. mm. Total serum protein was 5.5 Gm per 100 Ml. with 84 per cent globulins and 16 per cent albumins. BUN was 18 Mg. per 100 Ml.

On the second hospital day the patient had bright red bleeding from the rectum. Vital signs were stable. Temperature was 99.5°F. (37.5°C). Three days later, the same bleeding appeared, and the patient had fever of 102.2°F. (39°C). That day, WBC was 2,740 per cu. mm., with 85 per cent neutrophils, 11 per cent lymphocytes and 4 per cent monocytes. Platelet count was 178,000 per cu. mm., bleeding time 3 minutes, clotting time 18 minutes, prothrombin time 17 seconds, control 14 seconds, and clot retraction 3 hours. Fever persisted and two days later bone marrow aspiration revealed a very cellular marrow with an increased number of plasma cells, many of which were atypical. There were several multi-nucleated plasma cells with nuclei of unequal size showing dissimilar condensation of chromatin. Some of the cells were distributed focally in groups. This finding was compatible with the diagnosis of multiple myeloma (Fig. 2). However, sections of Zenker fixed clot stained with hematoxylin and eosin revealed miliary necrotic areas with little cellular reaction. Stain for acid fast bacteria was positive. The microscopic diagnosis was acute miliary tuberculosis (Fig. 3).

Although antituberculous therapy was started immediately, the temperature remained elevated, and two days later the patient died.

Microscopic Postmortem Findings

The microscopic study of sternum, rib, and vertebra revealed a hyperplastic marrow with reduction of fat due to increased number of plasma cells primary. In all sections acute miliary tubercles were identified, but these did not, by themselves, account for the increased cellularity of the bone marrow. Acute miliary tuberculosis was identified in sections of the right lung, spleen, adrenal, and brain as well. Staining for amyloid was negative. Culture of kidney, spleen, and vertebra revealed abundant colonies of *mycobacterium tuberculosis var. hominus.*

Discussion

The diagnosis of multiple myeloma today is significantly improved after introduction of more elaborate

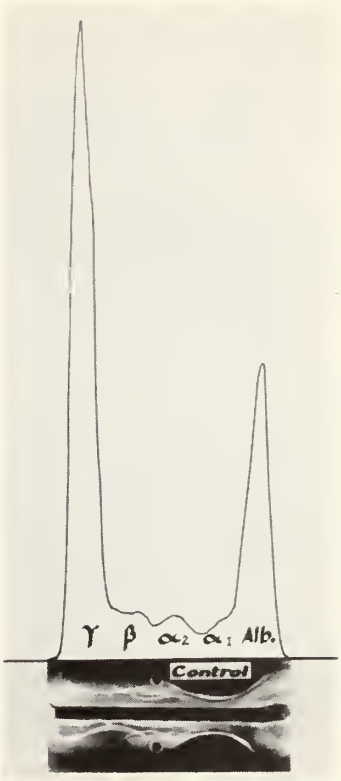


FIG. 1. *Electrophoresis showing a peak in gamma globulins. Immunoelectrophoresis showing a monoclonal protein of the gamma G variety.*

studies of serum proteins. The finding of increased number of plasma cells in the bone marrow remains an essential diagnostic criterion, but many other diseases, including infection may be associated with plasmacytosis of the bone marrow.[8-12, 14] It is difficult on morphologic or numerical grounds alone to distinguish the myeloma plasma cells from the nonmyeloma plasma cells.[6, 11] Therefore, a definite diagnosis of multiple myeloma should be made only after the appropriate combination of the clinical and laboratory findings and, when possible, immunoelectrophoresis.

This patient represents a typical case of multiple myeloma, showing abnormal plasmacytosis of the bone marrow in combination with plasma protein abnormalities. The inflammatory process of the lung was most probably a complication of the underlying myelomatous disease and was treated appropriately. Hemorrhagic complications are not infrequent in patients with multiple myeloma, but routine laboratory studies usually do not show significant changes.

Preparation of histologic sections of the clot from the bone marrow aspirate should be part of the routine study of bone marrow since the diagnostic value of bone marrow sections has been well established.[13-16] Although bone marrow aspiration in this case revealed scattered necrotic miliary areas with little

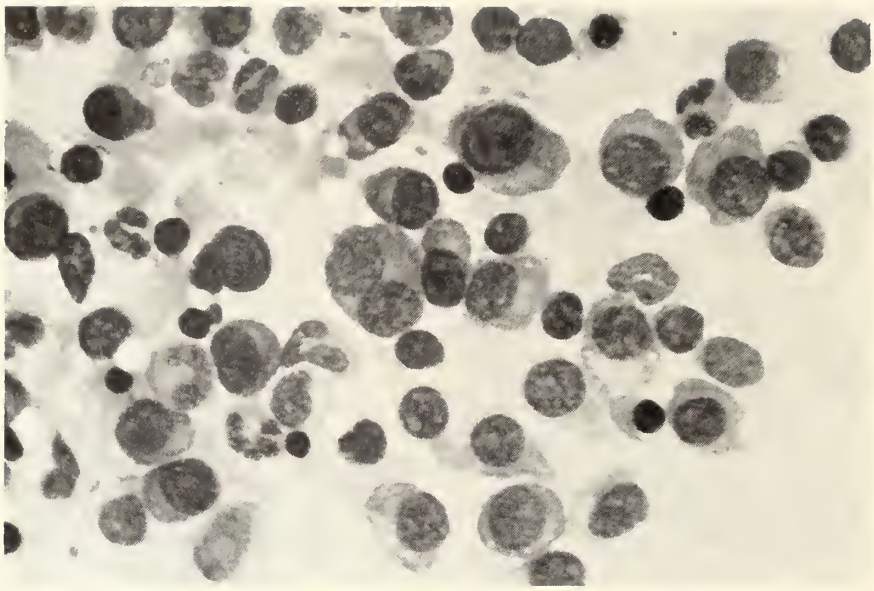


FIG. 2. *Bone marrow smear showing atypical plasma cells (Wright stain, X 450).*

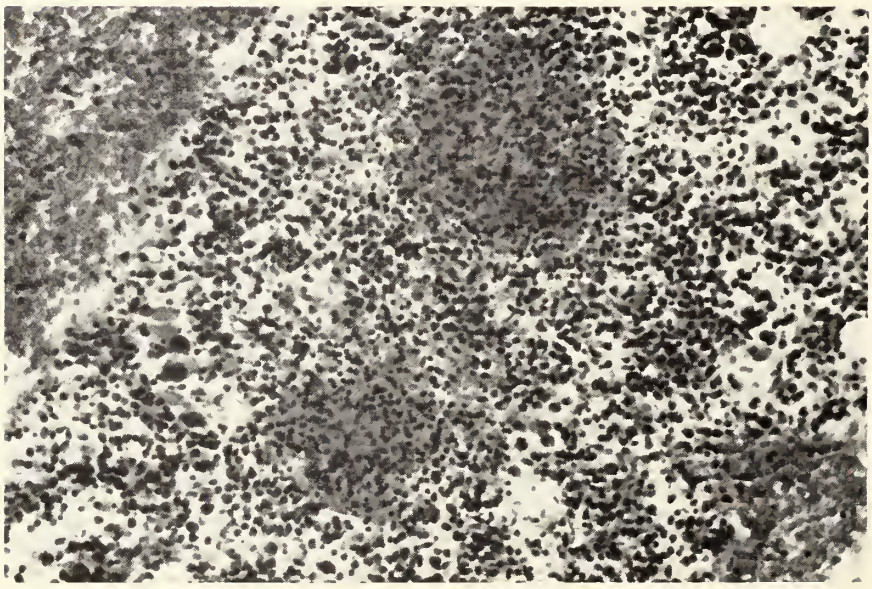


FIG. 3. *Section of the bone marrow showing miliary granulomas with centrally necrotic areas. (Hematoxylin and eosin stain, S 450).*

cellular reaction, such findings have been considered atypical for tuberculosis.[17] However, the diagnosis of acute miliary tuberculosis was confirmed antemortem by the demonstration of acid fast organisms in the bone marrow section and a positive culture for miliary tuberculosis taken from bone marrow, spleen, and kidney postmortem.

Summary

A patient with the unusual combination of multiple myeloma and acute miliary tuberculosis diagnosed antemortem has been described. The significance of bone marrow examination in the diagnosis of miliary tuberculosis has been reemphasized and of particular importance is the histology of sections of the clot from bone marrow aspirate.

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TUBERCULOUS MENINGITIS IN ADULTS. — The acquisition of tuberculous infection in adult life combined with the propensity of meningitis to follow primary, rather than reinfection, tuberculosis, can be expected to result in tuberculous meningitis becoming increasingly a disease of adults. It should be suspected in any patient with a falling C.S.F. sugar, a lymphocytic pleocytosis and no growth on routine bacterial and fungal cultures. Severe headache, fever, nuchal rigidity and paralysis of extraocular muscles are early findings. Miliary disease is helpful but detected during life in less than one-third of patients. The absence of past or contact history with tuberculosis and a positive skin test do not preclude the diagnosis. The level of consciousness and marked increases in spinal fluid protein appear to correlate best with the prognosis, but even comatose patients with localized neurologic deficits can make a complete recovery with the prompt institution of antituberculous therapy. The age of the adult patient does not appear to be a prognostic factor. — Elizabeth Barrett-Connor, M. D., Miami, Fla.: *Southern Medical Journal,* 60:1061 - 1067, October, 1967.

Middle-Lobe Syndrome Following Pneumonitis Due to Retention of Bronchographic Contrast Medium

GERASIMOS H. PENTOGALOS, M. D., and JOHN E. AVGOUSTINIATOS, M. D.

THE ETIOLOGY of the 'Middle-Lobe Syndrome' is extremely variable. Neoplasms or inflammation, either within the lung tissue itself or in remote situations,[10] histoplasmosis,[1] and lymphadenitis due to lesions in neighboring organs[11] have all been described as predisposing causes. In five cases of pneumoconiosis described by Ellis,[5] tuberculosis was a concomitant finding, although in the sixth case, a patient aged 72, the sole cause of the syndrome was the tissue reaction set up by the irritant.

The curious case described below is that of a middle-lobe syndrome resulting from insufficient evacuation of an oily contrast medium following bronchography in a patient suffering from bronchiectasis.

Case Report

The patient, a 58-year-old housewife and part-time agricultural worker suffering from asthmatic episodes of the allergic bronchitis type, had suffered progressive increases in the severity of her attacks during the winter months for several years.

She had been admitted to hospital some two years previously at which time, in addition to asthma and bronchitis, she was suffering from right-sided pleurodynia associated with coughing in the morning often accompanied by blood-stained sputum. Her general condition was good and she was apyrexial.

Chest x-ray (Fig. 1) revealed emphysema particularly marked in the right lower lobe and bronchography of the right lung was carried out on March 28, 1964 using 40 per cent lipiodol mixed with sulphonamide powder (Fig. 2). The radiologist's report read: "Bronchiectasis with many sac-like protrusions in the lower lobe." No further radiologic examinations were made, and the patient was discharged from the hospital on June 4, 1964 with a diagnosis of bronchiectasis of the right lung and suspected associated bronchiectasis of the left lung.

The patient was first seen by the authors some nine months later, on March 10, 1965, at which time she complained of right-sided chest pain, difficulty in breathing, persistent cough, and occasional fever, which responded to treatment with penicillin and streptomycin. Repeated sputum examinations for tubercle bacilli proved negative. A chest x-ray in the A-P position (Fig. 3) showed a curiously shadowed picture; however, the lateral view (Fig. 4) showed a clearly-defined uniformly opaque triangular shape with its apex close to the hilum of the lung and its base close to the anterior thoracic wall. Since this picture was sufficiently distinct, bronchographic examination was not repeated and bronchoscopy not performed, a diagnosis of middle-lobe syndrome being made and thoracotomy advised.

The operation was carried out on April 20, 1965 at Mantzavinateion Hospital by the authors. Dissection of the bronchial hilum, although relatively simple, required an incision slightly longer than usual along the bronchus on account of an adjacent small aberrant artery. Lobectomy of the middle lobe was complicated by firm adhesions between this and the lower part of the upper lobe, and, in consequence, small portions of the diseased lobe which were firmly adherent were allowed to remain. The post-operative progress was good and one month later an x-ray of the thorax showed satisfactory results, the patient returning home after six weeks.

Biopsy of the middle lobe specimen was carried out on May 1, 1965 by Dr. A. Theodosiou, Assistant Professor at Athens University Hospital, who reported that on macroscopic examination marked contraction was present, cut sections revealing a tough consistency with a dirty greyish hue, in parts grey-black or greyish white in colour. The histologic report was as follows:

"The parenchyma of the lung has been largely re-

Submitted January 9, 1968.

The Authors

- **Dr. Pentogalos is Chief, First Surgical Department, Valianeion Hospital, Cephalonia, Greece.**
- **Dr. Avgoustiniatos is Resident Assistant, Surgical and Gynecological Wards, Tzanneion Hospital, Pireaus, Greece.**

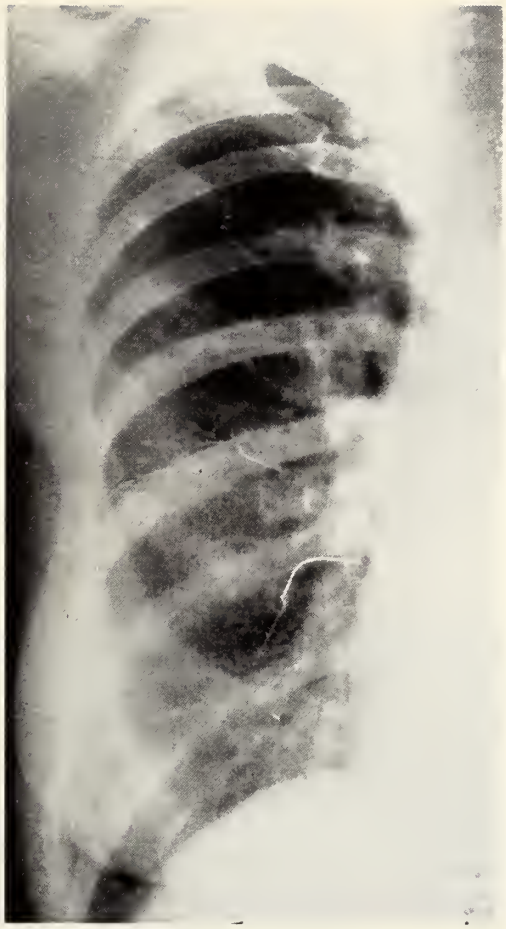


FIG. 1. *Roentgenogram of right lung demonstrating emphysema.*



FIG. 2. *Bronchogram of right lung showing bronchiectasis.*

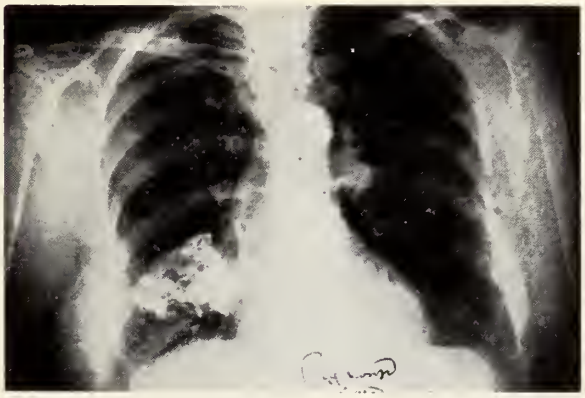


FIG. 3. *A-P roentgenogram of thorax. Curious shadow in lower part of right lung.*

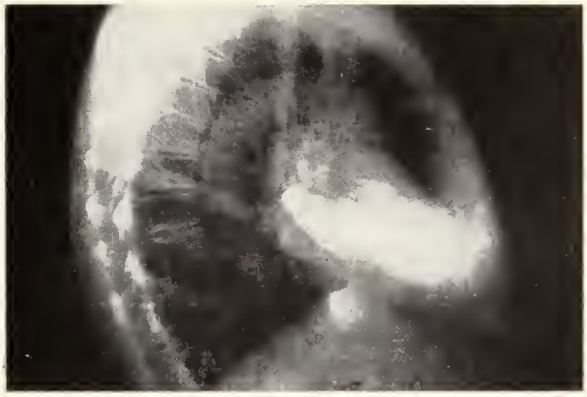


FIG. 4. *Lateral roentgenogram of thorax. Triangular homogeneous shadow with apex at hilum and base towards anterior chest wall. Sharply defined. (Typical picture of middle-lobe syndrome.)*

placed by numerous, and in some places confluent, lymphocytic infiltrations. These are mainly in the form of follicles having fairly large germinal centers, the cell elements of which, however, do not possess malignant features. Among the dense follicular masses small swollen bronchioles are seen possessing a well-maintained tall cylindrical epithelium. The bronchial lumen in many instances contains abundant lymphocytes and a considerable number of eosinophilic polymorpho-nuclear cells with, in places, a few large polynuclear giant cells of an indefinite type. Among these cell elements, many isolated lipid

droplets can be seen and also some short, oblong, light-refractive particles of a foreign nature (crystal?). In places dense infiltrations of cosinophilic polymorphonuclear cells are seen in the mass of hyperplastic and hardened connective tissue which surrounds the small bronchi previously mentioned. Alveoli are sparse. Adjacent to the hyperplastic and hardened pleura, abundant deposits of anthracotic pigment were noted. The lumen of the blood vessels contained, apart from other cell elements, relatively abundant eosinophilic polymorphonuclear cells.

Conclusions: Marked collapse of the lung of the atelectatic type due to obstruction was noted resulting from interstitial lymphonuclear pneumonitis with pronounced changes in the parenchyma. Collections of phagocytes containing giant cells of a nonspecific type which were observed had developed around the lipid droplets."

The patient was again examined six months after operation, on November 6, 1965. The A-P x-ray of the thorax (Fig. 10) showed completely satisfactory results. A bronchogram of the right lung, made at the same time, using a water-soluble radiographic substance (Dionosil - Glaxo) again showed the presence of bronchiectatic foci in the lower lobe and confirmed the satisfactory results of the operation (Fig. 11).

Discussion

1. Etiology of the Middle-Lobe Syndrome.

It is clear that the contrast medium used for the first bronchographic examination (Lipiodol® with sulphonamide powder) was the cause of the condition. Since the middle lobe was already subject to bronchiectatic changes, only with difficulty could it completely evacuate the fluid administered. Suction of the bronchi to remove the medium following bronchography was not carried out, nor was a subsequent x-ray examination made of the thorax, which would have indicated the need to evacuate the bronchial system even though this would have been delayed. The patient, who lived in a remote village was only examined again some nine months later.

The bronchiectasis, as a result of asthmatic bronchitis of allergic origin, affected the whole right lung as shown by examination; however, as is well known, the peculiar anatomy of the middle lobe renders it more liable to obstruction with retention of the contents of the bronchi than any other part of the lung. In our case this was aggravated by the mass of secreted mucus and contrast medium which together formed a viscous discharge.[9] At operation, swelling of the lymph nodes at the base of the middle lobe bronchus was not found; this does not mean, however, that these nodes were not subject to swelling at some time in the past thus producing pressure on the lumen of the bronchus.

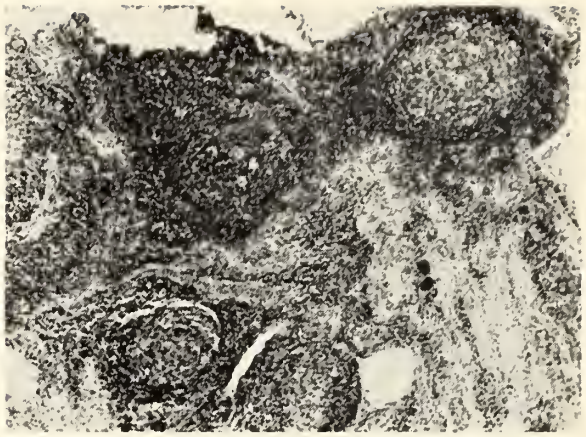


FIG. 5. *Section of middle lobe (L.P. magnification) demonstrating fibrosis and leucocytic infiltration with formation of follicles.*

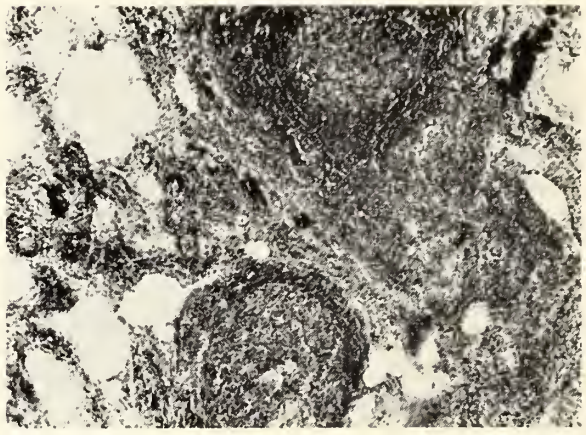


FIG. 6. *Section of middle lobe (L.P. magnification) showing lymphocytic infiltration and occasional carbon deposits.*

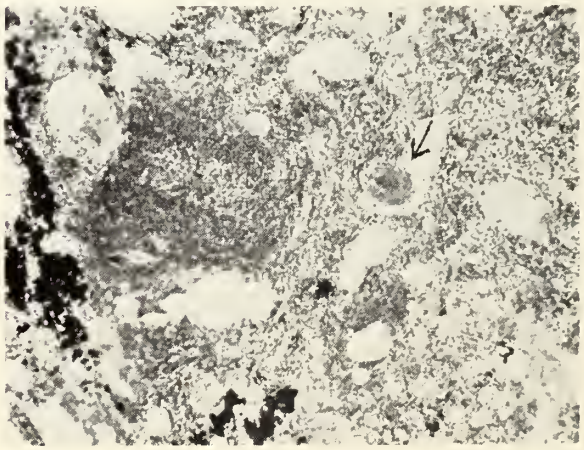


FIG. 7. *Section of middle lobe (L.P. magnification) showing:*

(a) Left center lymphocytic infiltration
(b) Giant cell of nonspecific type (arrowed)
(c) Spaces possibly due to dissolved oily material
(d) Carbon deposits.

2. **Histologic Findings.**

The presence of abundant eosinophilic leucocytes within the lumen of the blood vessels and in the parenchyma confirms the clinical diagnosis of underlying asthmatic bronchitis of an allergic nature. The main cause of the condition was the presence of lipid droplets and sulphonamide powder found in the form of oblong light-refractive particles. Particularly notable was the reaction of the patient's body to the pharmaceutical substances in the lung: giant cells of a nonspecific type which were in close proximity to the lipid droplets. This can be clearly seen in the photographs. The histologic picture of the parenchyma of the lung in our case possesses certain similarities to that of the middle-lobe syndrome due to pneumoconiosis described by Ellis.[5] There also was a deterioration of the parenchyma due to the presence of an irritant, similar to the hyperplastic and hardened connective tissue in our case, although the giant cells were of the Langhans type.

3. **Examination for Tuberculosis.**

Tuberculous infection of any kind diagnosed clinically or by laboratory examination was not only not found but its existence was considered improbable. Hence no preoperative antituberculosis treatment was given as is recommended in this type of case by many practitioners. A rapid biopsy was not performed during the operation, since there was no specialist available.

4. **Possible Explanation of Origin of the Syndrome.**

Edema of the mucous membrane of the bronchi due to irritation caused by the substances administered for the bronchogram was the initial cause of retention of mucus and contrast medium in the bronchial network of the middle lobe. Contributory factors were the anatomical features of the middle lobe bronchus, the sac-like protrusions resulting from bronchiectasis and the viscous contrast medium and secretions. Prolonged occlusion and pneumonitis followed. It is possible that this inflammation may have induced swelling of hilar lymph nodes increasing the degree of occlusion. Permanent atelectasis ensued with no reexpansion, as has been noted in some cases of the middle-lobe syndrome.[2] Hence, the retention of part of the contrast medium in the lobe produced the curious x-ray picture and contributed to the development of an inflammatory tissue response.

Conclusion

Special care should be exercised in dealing with the middle lobe of the right lung when it is subjected to various endobronchial examinations. It is certain that the use of water-soluble contrast media such as Dionosil, instead of oily substances, reduces the probability of this kind of occurrence. The use of oily contrast media continues to be preferred by some practitioners on the grounds that it produces a more detailed and clearer picture and that it affords a greater span of time in which to take subsequent x-rays. We believe that the findings in our case will induce a reassessment of these views.

The satisfactory postoperative result obtained is proved not only subjectively by the patient but also by the x-ray findings, and its verifies the established opinion[1] that, in a clinically substantiated middle-lobe syndrome which is the cause of symptoms, surgical intervention is indicated.

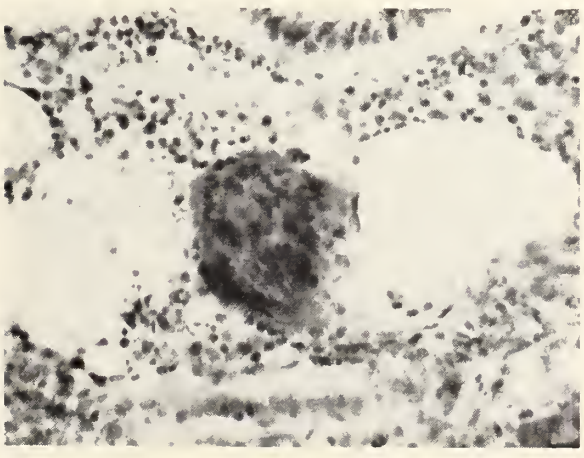


FIG. 8. *Section of middle lobe (H.P. magnification) showing polynuclear giant cell between two spaces possibly due to dissolved oily substance and transverse section of bronchiole containing cylindrical cells (upper right).*

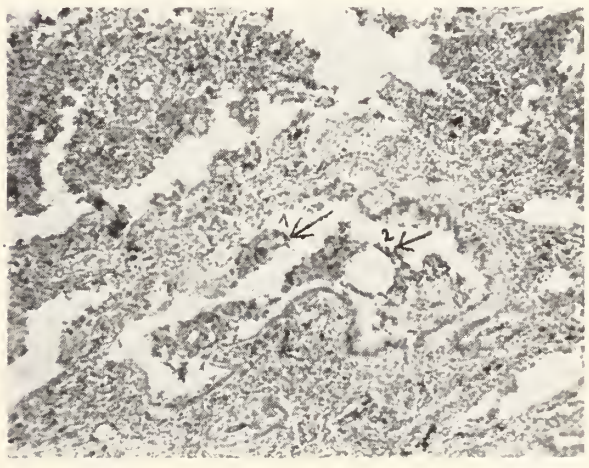


FIG. 9. *Section of middle lobe (L.P. magnification) showing giant cells of nonspecific type within the lumen and adjacent to the wall of a bronchiole. Exudate with empty spaces due to dissolved oily substance.*



FIG. 10. *A-P roentgenogram of the thorax six months postoperative. We note that the right lower lobe is dilated. A barely discernible small shadow (at the base of the upper lobe) is due to small portions of the parenchyma of the middle lobe adhering to the lower surface of the upper lung which were not removed.*

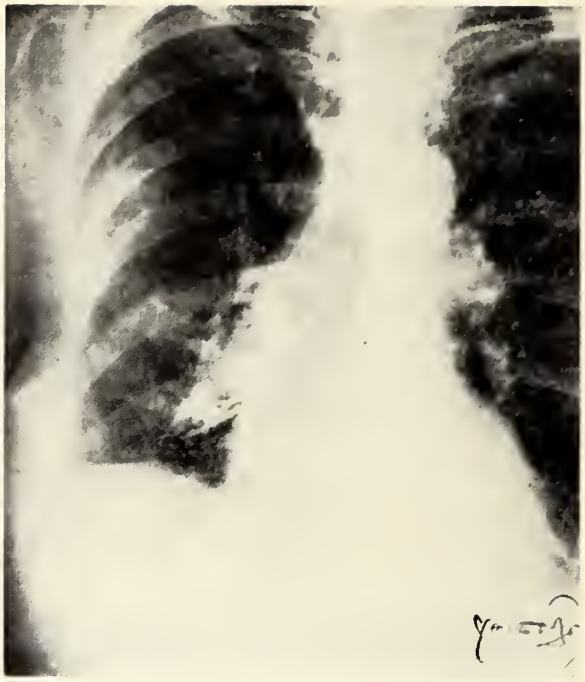


FIG. 11. *Bronchogram of the right lung showing the initial findings of bronchiectasial deterioration of the lower lobe, certifying surgery.*

Summary

A case of middle-lobe syndrome subsequent to the use of oily contrast medium for bronchographic examination in a patient suffering from allergic asthmatic bronchitis is described. The possible causation of atelectasis by retention of mucus and contrast medium and by enlargement of hilar lymph nodes is demonstrated. Histopathologic findings during and subsequent to lobectomy are described and satisfactory postoperative results are recorded.

Acknowledgment: We express our thanks to Dr. A. Theodosiou, Assistant Professor, Athens University Laboratory of General Pathology, for the histologic study and the photographs. We also thank the radiologist, Dr. Z. Panticas, for the radiologic study.

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THE TIME IS PAST when the keen clinician could afford to turn his back on medical politics. Like it or not, political factors vitally affect clinical medicine by largely determining the conditions under which it can be practiced. — Martin Ware, M. B., F. R. C. P., London: *The New England Journal of Medicine,* 278:3-5, January 4, 1968.

Ectopic Pregnancy with Intra-Uterine Device—A Case Report

Capt. RICHARD P. DICKEY, M.C., USA, and Capt. STANLEY A. GALL, M.C., USA

ECTOPIC PREGNANCY should be considered whenever a woman with an indwelling Intra-Uterine Device (IUD) has signs and symptoms of pregnancy. The present report describes a case in which tubal pregnancy was diagnosed eight months after insertion of an IUD. Prior to this a different type of IUD had been successful in preventing pregnancy for eight months. Removal of the first IUD was followed by an uncomplicated intra-uterine pregnancy.

Case Report

A 28-year-old white woman, Gravida 3, para 2, whose last menstrual period was ten weeks previous, was admitted to the Emergency Room with acute abdominal pain of six hours duration, right shoulder pain, and syncope. For the preceding six weeks she had symptoms of pregnancy. She had been fitted with a Lippes Loop D eight months before, six weeks after delivery of her second child by cesarean section. She had become pregnant for the first time immediately after marriage and was delivered by cesarean section because of cephalopelvic disproportion. Six weeks after her first delivery, a Margulies coil had been inserted. This functioned well for eight months and was removed so that she could conceive again, which she did immediately.

On pelvic examination the uterus could be palpated as upper normal size. A mass was present in the left adnexae. Two strands of nylon thread each 1½ inches long were protruding from the cervical os. Culdocentesis yielded bloody fluid. She was taken to surgery shortly thereafter where a 6 cm. ruptured ectopic pregnancy was found in the distal third of the left fallopian tube. The opposite tube was normal, and there was no evidence of pelvic inflammatory disease. An x-ray taken six days after surgery revealed an IUD in proper position in the uterus.

Comment

In a review of 588 pregnancies which occurred with an IUD in situ, Tietze found that one in 23 was a tubal pregnancy.[1] In the same series, the overall pregnancy rate was 2.8 per 100 women years. In smaller series, tubal pregnancies have been reported to comprise an even greater proportion of all pregnancies which occur in the presence of an IUD.[2,3]

From DeWitt Army Hospital, Fort Belvoir, Virginia. Submitted January 12, 1968.

The Authors

● **Dr. Dickey, Springfield, Virginia, former Instructor, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus, presently member of the Attending Staff, DeWitt Army Hospital, Fort Belvoir, Va.**

● **Dr. Gall, Miami, Fla., former Medical Officer, DeWitt Army Hospital, Fort Belvoir, Va., presently associated with Department of Obstetrics and Gynecology, University of Miami School of Medicine.**

By contrast the incidence of ectopic pregnancy without IUD is considered to be one in 200 deliveries among white women.[4]

Attention is called to the finding of a nylon thread protruding from the cervix in this case. When this occurs in association with symptoms of pregnancy and a last menstrual period ten weeks or more previously, it is possible evidence of extra-uterine pregnancy. In our personal experience, the nylon thread of an IUD is pulled up into the uterus by the tenth week of pregnancy. An exception to this is the case reported by Vago and Spira, where pregnancy occurred in one side of a bicornuate uterus after insertion of an IUD in the opposite side.[5]

Summary

1. A case of tubal pregnancy in the presence of an intra-uterine device (IUD) is reported.

2. Ectopic pregnancy should be considered whenever a woman with an IUD develops acute abdominal pain in association with any of the common symptoms of pregnancy.

3. The finding of a nylon thread protruding from the uterine cervix after the tenth week of amenorrhea in association with symptoms of pregnancy is possible evidence of ectopic pregnancy.

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Heart Page

Peripheral Vascular Disease

IX. Lymphedema

RAY W. GIFFORD, JR., M.D.

LYMPHEDEMA results when peripheral lymphatic vessels are incompetent, underdeveloped, or obstructed. Initially, the edema is soft; it disappears during elevation of the extremity; and pitting is readily demonstrable. However, the protein-rich lymph serves as an excellent culture medium for fibroblasts, and ultimately subcutaneous fibrosis occurs, causing a firm, incompressible, permanent enlargement of the limb (usually one or both lower extremities), which may reach grotesquely huge proportions if adequate elastic support is not applied faithfully in the early stages. At first, the skin is smooth and pale; later it becomes thickened and puckered, not unlike an orange peel. In the advanced stage, the thickened skin becomes rough and corrugated and has the consistency of wood. The extremity resembles a tree trunk. The term elephantiasis is appropriately descriptive of this far-advanced stage of lymphedema, but has no etiologic connotation. Typically, the foot is not affected when shoes are worn regularly, hence the edema stops abruptly just below the ankles. The toes assume a rectangular rather than a cylindric configuration.

While frequently bilateral, lymphedema rarely produces symmetric enlargement of both lower extremities. When bilateral, it usually begins first on one side and affects one limb to a greater extent than its mate. This feature serves to distinguish it from "idiopathic" edema of women, lipedema, edema of congestive heart failure, and nephrotic edema, all of which cause bilateral and symmetric enlargement of the lower extremities. In the early stage, lymphedema may be confused with chronic venous insufficiency, which is frequently unilateral. A history of acute thrombophlebitis and/or varicose veins, and the presence of extensive collateral venous channels in the leg and ankle are clues to the diagnosis of chronic venous insufficiency. In more advanced stages, chronic venous insufficiency causes brownish pigmentation and subcutaneous induration with or without ulceration in the malleolar regions. The induration of lymphedema is not so well localized. Enlargement of the thigh occurs more frequently with lymphedema than with chronic venous insufficiency. Acute iliofemoral thrombophlebitis affects the leg and thigh, but it comes on abruptly, usually after operations, parturition, or trauma; lymphedema begins insidiously and painlessly and only after several months or years does it affect the thigh.

Lymphedema may be primary (idiopathic) or secondary. The most common form of primary lymphedema is "lymphedema praecox," which usually appears between the ages of 10 and 30 years in women. The first symptom is painless, pitting edema of one ankle. Progression is usually inevitable, but slow, and the opposite extremity may become edematous at a later time. Congenital, hereditary lymphedema (Milroy's disease) is a rare form of primary lymphedema. Lymphangiograms usually show hypoplasia and/or incompetence of lymphatics in patients with primary lymphedema.

Secondary lymphedema results from obstruction to lymph flow. Chronic, low-grade cellulitis or recurrent acute attacks of cellulitis (often associated with dermatophytosis of the feet) can lead to scarring and occlusion of lymphatic vessels and to chronic lymphedema (inflammatory lymphedema). In this regard, it should be mentioned that recurrent attacks of acute cellulitis frequently occur in limbs with primary forms of lymphedema, but only *after* the edema has been present for several months or years. Secondary lymphedema can be caused by chronic inflammatory changes in lymph nodes, tumor invasion of lymph nodes (lymphoma or metastatic carcinoma), by scarring of lymph nodes from irradiation, or by surgical extirpation of lymph nodes. Lymphedema of an upper extremity is almost always the result of radical mastectomy for carcinoma of the breast.

When unilateral lymphedema begins in middle or later life, malignant obstruction of lymph nodes should be suspected—usually prostatic carcinoma in men and lymphoma in women.

Progression of lymphedema can usually be prevented if the patient faithfully wears an adequate, well-fitted elastic support on the affected extremity. Edema should be reduced to a minimum by elevation of the leg for two or three days before the support is fitted and applied. Continuous or intermittent administration of oral diuretics is helpful, but is not a substitute for adequate elastic support. When recurrent infection is a problem, special attention should be given to eradication and prophylaxis of dermatophytosis. Plastic procedures to reduce the size of an enormously enlarged limb should be reserved for far-advanced cases.

A rare complication of chronic lymphedema, usually in the upper extremity, is the development of lymphangiosarcoma, a highly malignant neoplasm.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association. — ED.

From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio.



NEWS AND Organization Section

Physician Involvement in Areawide Planning--Fact or Fiction?

By WARREN G. HARDING, 2nd, M.D., Administrator, Grant Hospital, Columbus
and CLAY HERRON, Administrative Resident, Grant Hospital

THE HOUSE OF DELEGATES of the American Medical Association, in its November, 1962 session recommended ". . . that the medical profession demonstrate cooperation and exert leadership in the formation and operation of . . . planning bodies." This recommendation subsequently was adopted as policy by the AMA in an attempt to influence physician involvement in areawide health planning. However, the ensuing individual physician interpretation of this policy has shrouded it with controversy and perplexity.

This controversy and perplexity have been nourished by numerous ambiguous articles appearing in the national and state professional journals exhorting the physicians to "become involved." Like the policy statement of the AMA, these exhortations lack definitive statements of direction for the physician as interpreted by him.

This dilemma gave inception to a survey of 400 physicians practicing within the 36-county planning area of the Columbus Hospital Federation. The survey was conducted during April and May, 1968, with the objective of ascertaining to what extent individual physicians were involved in areawide health planning and whether or not they desired to be involved.

A startling revelation is that only 34 per cent of the responding physicians are familiar with any of the concepts embodied in areawide health planning. Apparently, this understanding is superficial at best, because less than 19 per cent of the respondents are familiar with the AMA's and state association's policies relating to areawide health planning according to their own admission.

Impels Intervention

This lamentable condition gives impetus to intervention in areawide health planning by nonvoluntary organizations; namely, if the medical profession leaves a void, some other group will occupy that void. Members of many of these groups have little if any basic medical background of the requirements. Indeed, some are oriented in conflict with the medical care team as a basic philosophy.

Ninety-one per cent of the physician respondents are members of their national and state medical associations. This means that they are on the mailing lists of the associations and are recipients of the numerous materials distributed by these organizations, in addition to the professional journals received. Therefore, the lack of physician knowledge about areawide health planning is caused either by inadequate publication of relevant materials by the association or neglect by the physicians to read such materials.

The physicians blame the associations and planning agency. Their attitude, as revealed by the survey, indicates that the concepts of areawide health planning have not been sufficiently publicized or explained by these organizations. In fact, 82 per cent of the physicians feel the problem has its genesis with the professional organization and the areawide planning agency. (See questions 6, 7, 8.)

Diametrically opposed to the physician attitude is

the Ohio State Medical Association's position that it has supplied the membership proper and adequate information designed to inform, interest, and stimulate active involvement in areawide planning. A review of back issues of *The Ohio State Medical Journal* and materials mailed to the membership substantiate this claim.

The Columbus Hospital Federation, whose sole purpose for existence is to plan, coordinate, and direct community health care programs, profoundly declares that the physicians residing and practicing in the federation planning area are well-informed about the agency programs. Evaluation of the informational and public relations program of the federation attests the validity of their position.

The federation, to increase planning capabilities, has included physicians by membership on every committee in the planning organization. As a result of this membership, the local county societies are well represented. However, the 82 per cent of the responding physicians who feel they are not sufficiently informed by these organizations, in fact, are not. Why?

First, one needs only to see the preponderant flow of materials that reach a physician's desk to sympathize with the need for larger wastebaskets. Time does not exist for scrutiny and evaluation of every piece of mail. Consequently much of the pertinent literature concerning areawide health planning is discarded.

Stimulation Is Necessary

Second, many of the articles that do attract the physicians' attention lack any degree of stimulation because of their ambiguous content.

Lastly, many of the articles that do appear in the journals and mail distribution often go unread and unheeded because of a more serious reason — fear of socialized medicine. Many physicians are convinced that areawide health planning is a step toward socialized medicine. Question Number 13 on the questionnaire, "Do you feel areawide health planning is a move toward socialized medicine?" was either answered affirmatively or with uncertainty by 76 per cent of the responding physicians. Ninety-nine per cent do not favor socialized medicine.

This attitude was expected. Socialized medicine has long been feared by the AMA. The free and private practice of medicine is threatened by the potentiality of its existence. Ironically, this "threat" is not taken too seriously by the individual physician.

Complacency prevails in lieu of opposition. This complacency is evidenced by the fact that one-third of the physicians care enough to be knowledgeable about any facet of areawide health planning. The federal government is consistently and meticulously making numerous "seed" and pilot project grants for establishing and operating of areawide health planning agencies and counsels.

In effect, these project grants are creative federalism at work. Creative federalism can flourish and grow only in an atmosphere of social vacuum. Is this process not a major step toward socialized medicine?

Lack of individual physician involvement and interest in the areawide health planning program encourages this internecine complacency.

This individual disregard for assuming responsibility has a twofold impact on the medical profession: it provides an inroad for additional governmental intervention — and every time planning programs are created or turned over to the government a certain measure of freedom is lost; secondly, if the citizens feel that the physician is not concerned with the communities' total health care needs in addition to their patients' care, the profession weakens its community and civic leadership potential.

Who Will Carry the Ball?

The consequences of this individual laxity was expressed by Dr. Edward Crane, Jr., past president of the Los Angeles County Medical Society, addressing the First National Conference on Areawide Planning in Miami, November, 1964. He stated, ". . . future neglect of our responsibilities will result in hospitals, public health and planning organizations carrying the ball alone, and the goal line they cross might not be best for either our patients or the practice of medicine."

In a recently completed study on hospital effectiveness directed by the Secretary, Department of Health, Education, and Welfare, emphasis was directed at a strong participation of physicians in the areawide health planning programs. The study declared, ". . . it is important for physicians to take part in formulating the institutional plan not only because their patients and their responsibilities and their practices are central to the achievement of institutional goals, but more particularly because medical staff and individual physician decisions and actions have a significant influence on every aspect of institutional effectiveness from internal hospital management to developmental goals and inter-institutional plans for referrals and shared services."

Response to this challenging pronouncement must come collectively from professional associations and planning agencies and individually from the practitioner. Arriving at a comprehensive planning program that will include a majority involvement of the medical profession working with the professional associations and planning bodies will require a two-way street. The associations and agencies must intensify their efforts to apprise the membership of the progress made in the planning programs. This means that communication materials must be de-

PHYSICIAN QUESTIONNAIRE ON AREAWIDE HEALTH PLANNING WITH COMPILATION OF REPLIES

A. Type of geographic area to which your practice is primarily limited:

Urban 59%
Suburban 33%
Rural 8%

B. The following types of practice are the major classifications recognized and defined by the American Medical Association. Please check the type that is applicable to you.

28% Full time General Practice
54% Full time Specialty Practice
8% General Practice with some Specialty Serv.
4% Intern in Hospital Service
2% Resident or Fellow in Hospital Service
Full time medical school faculty
Administrative Medicine
3% Laboratory Medicine (path., etc.)
Preventive Medicine
Research
1% Retired
Not in Practice

	Percent		
	Yes	*No*	*Uncertain*
1. Are you a member of the American Medical Association?	91	9	
2. Are you familiar with the concepts embodied in areawide health planning?	34	62	4
3. Do you favor areawide health planning?	43	39	18
4. Are you familiar with your local medical association's policy relating to areawide health planning?	19	77	4
5. Are you familiar with the AMA's policy relating to areawide health planning?	17	80	3
6. Do you feel the concept of areawide health planning has been adequately explained to you by the responsible areawide health planning agency in your area?	9	84	7
7. Do you feel the concept of areawide health planning has been adequately explained to you by the national professional organization(s) to which you belong?	6	83	11
8. Do you feel the concept of areawide health planning has been adequately explained to you by the local professional organization(s) to which you belong?	9	82	9
9. Have you received any questionnaires from an areawide health planning agency (national or local)?	7	93	
10. Have you been actively solicited for support of areawide planning for the area in which you practice?	6	94	
11. Are you an active member of an areawide planning agency or council?	1	99	
12. Would you participate in such an agency or council if asked to do so?	31	35	34
13. Do you feel areawide health planning legislation is a move toward socialized medicine?	55	20	25
14. Do you favor socialized medicine?	2	98	

signed that attract physician attention. The survey shows that an average of eight per cent of the physicians answered questions 6, 7, and 8 affirmatively, indicating they feel present written communications from the associations and planning agencies lack stimulation and interest. Seven per cent have received questionnaires from either the local or a national planning agency while six per cent have been solicited for active support of the areawide planning program in their area.

What Organizations Can Do

In addition to the distribution of informational materials, the organizations must make efforts to stimulate physician interest through association, agency, and community meetings where a considerable portion of the time will include discussions about areawide planning concepts.

An active speaker service can be activated, composed of knowledgeable physicians and areawide planners who can advise local societies in planning activities.

Constant liaison must be maintained with all governmental and voluntary agencies involved in implementation of areawide health planning legislation.

To be successful, all of these activities must be coordinated by the organizations concerned and a concerted effort made to involve the physicians. The language used must eliminate technical abbreviations with which the physician is not familiar and hence loses interest early in the discussion.

What the Physician Can Do

Likewise, the physicians must assume more responsibility. This can be done in several ways.

Generally, he must promote and participate in voluntary planning of health services and facilities.

Specifically, a sacrifice of time must be made for involvement and attendance at areawide health plan-

ning programs and seminars sponsored by the planning agency and the professional organizations.

Share innovating ideas as well as constructive criticisms with peers and influential community members.

Promote participation by members of the hospital medical staffs in the long-range planning processes of the hospital they attend.

Support the professional association activities. Attend the scheduled meetings. Conscientiously read the information sent to you. Assist association leaders in their efforts to provide the planning agencies with consultation, advice, and direction.

Volunteer your services to the association and/or planning agency.

Develop an **active** interest in areawide health planning programs. Passive interest breeds complacency, uninvolvement, and inaction.

Assume leadership. No other profession is more prestigious nor can any other profession be more important to the planning of health care programs.

Exert a positive influence on planning body members and health care personnel.

New Role Emerging

Unquestionably, a new role is emerging for the physician. It is a unique challenge to the profession that the individual physician become an adviser, voluntarily, in planning progressive medical care for the community. This leadership and intellectual opinion is not only necessary but obligatory for the success of the planning program.

The knell of the Secretary's Report on Hospital Effectiveness will long be heard: "The physician who has taken part in the planning process may be expected to accept responsibility for the plans effectiveness, and the one who has not, may not."

Anatomy of the Mitral Valve Is New Film Topic

The American Heart Association and the Heart Association of Maryland have co-produced a 16mm film in color on the "Functional Anatomy of the Mitral Valve," of special interest to cardiologists and medical students.

Running for 29½ minutes the film correlates the anatomy and function of the normal and diseased mitral valve with hemodynamic events and heart sounds and murmurs. It was produced with a grant from Shell Companies Foundations, Inc. Drs. J. Michael Criley and Richard S. Ross were the medical authors.

Prints of the film may be obtained for medical meetings on a loan or purchase basis through local Heart Associations or the Ohio State Heart Association, 10 East Town Street, Columbus, Ohio 43215.

Annual Pediatric Postgraduate Program Sponsored by OSU

The Annual Pediatric Postgraduate Program sponsored by the Ohio State University College of Medicine, Department of Pediatrics and the Columbus Children's Hospital, Columbus, Ohio will be held on September 26, 27, and 28, 1968. The program will consist of sessions devoted to problems of pediatric cardiology, hematology, and renology. General pediatric problems will be discussed and enrollees will be given ample opportunity to discuss specific problems with guest and staff faculty.

Guest speakers will include: David Cornfeld, M. D., Philadelphia Children's Hospital; Louis Diamond, M. D., Boston Children's Hospital; James G. Hughes, M. D., University of Tennessee, and J. A. Noonan, M. D., University of Kentucky Medical Center.

Tickets for the Ohio State University-Southern Methodist University football game on Saturday, September 28 are available.

Registration fee — $60.00. Registration may be made with William G. Pace, M. D., Director, Center for Continuing Medical Education, 320 West Tenth Avenue, Columbus, Ohio 43210.

PHS Booklet Deals with Chronic Disease Laboratory Services

A recently issued publication of the U. S. Public Health Service, Bureau of Disease Prevention and Environmental Control, is entitled "Programming Chronic Disease Laboratory Services." It is a summary of the 1967 multiregional seminars.

Among participants mentioned in the pamphlet text are four Ohioans, all associated with the Ohio Department of Health. They are Charles C. Croft, chief of the Bureau of Laboratories; Michael G. Ehrlich, M. D., heart disease control officer; Thomas A. Gardner, M. D., chief of the Bureau of Local Services, and since named assistant Department director; and Aileen L. MacKenzie, chief of the Division of Chronic Diseases.

AMA Occupational Health Program Scheduled in New York City

The 28th Congress on Occupational Health, sponsored by the American Medical Association is scheduled for the Waldorf-Astoria Hotel, New York City, Monday and Tuesday, September 30 and October 1.

The program is acceptable for 11 elective hours of credit by the American Academy of General Practice.

Representatives of state and county medical society committees on Occupational Health will meet on Saturday morning, September 28 with the AMA Council on Occupational Health.

Details may be obtained from the AMA at 535 N. Dearborn Street, Chicago, Illinois 60610.



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Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein® and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T^3 values; metyrapone test and pregnanediol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

Postpartum administration — Non-nursing mothers may begin Ovulen immediately after delivery and nursing mothers after lactation is well established.

SEARLE *Before prescribing see Detailed Product Information.*
G.D. Searle & Co., P.O. Box 5110, Chicago, Illinois 60680

Ovulen-21®
Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

three weeks on...one week off

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. T following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity react (e.g., blood dyscrasias, jaundice) to phenothiazine Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports c leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within t recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving) Orthostatic hypotension is more common in femal than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess c 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred visio constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticar type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significa disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arres have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiet and mixed anxiety-depressio

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J.

Ohioan Named AMA Vice-President At San Francisco Session

OHIO was highly honored when Dr. Carl A. Lincke, of Carrollton, was named, by acclamation, Vice-President of the American Medical Association at the 1968 Annual Convention in San Francisco, June 16-20. Other highlights of the meeting put Ohio and Ohioans in the spotlight, and paid tribute to the dedication of Ohio's delegation and other Ohioans who helped in planning and staging the 1968 Convention.

- Dr. Irvine H. Page, Cleveland, became the first recipient of the new "Doctor of the Year" title and the Sheen award for his outstanding contributions to the art and science of health and healing.

- The Ohio delegation received a high percentage of favorable action on a number of resolutions presented in the AMA House of Delegates.

- A plaque displaying research on the Aesculapean staff and the caduceus by Dr. Victor Laughlin, of Cleveland, was presented to the AMA and will be permanently displayed at the AMA Headquarters in Chicago.

- Numerous Ohioans participated in the AMA program and presented exhibits at the San Francisco convention. Their names and the parts they played were published in the May 6, or Convention Number, of *The Journal of AMA*.

- Ohio's Mrs. Carl Ritter presided at functions of the Woman's Auxiliary to the AMA, as 1967-1968 President of the organization.

Dr. Lincke Elected

Highlight of Ohio activities was the election of Dr. Carl A. Lincke as Vice-President of the American Medical Association.

Dr. Lincke's nomination was presented to the House of Delegates on behalf of the Ohio delegation and the Ohio State Medical Association by Dr. Richard L. Meiling, Columbus, who introduced him as "my friend, colleague, and fellow Buckeye." Dr. Meiling further described Dr. Lincke as "a practicing physician since 1932 in Carrollton, Ohio (who) has devoted his medical career to his patients, his community, and his profession.

"Dr. Lincke has served as President of the Carroll County Medical Society, as President of the Ohio State Medical Association, and for 23 continuous years as a delegate from Ohio to this House of Delegates of the AMA," Dr. Meiling said. "Thus in years of service he is the 'senior delegate' of this House. For 13 years he has served with distinction as a member of the Council on Scientific Assembly, and as this Council's chairman in 1961-1962. He has served repeatedy as both member and chairman of the numerous reference committees in his 23 years as member of this House."



Carl A. Lincke, M. D.

Dr. Lincke was first named an alternate delegate to the AMA in 1944 and was elected a delegate in 1946. He was first elected to The Council of the OSMA in 1942, after having served as President of the Carroll County Medical Society the previous year. He was named OSMA President-Elect in 1948 and served as President during the 1949-1950 period.

Dr. Lincke was one of the founders of Ohio Medical Indemnity — the Ohio Blue Shield plan — and served on the OMI Board of Directors and its Executive Committee.

Dr. Page Honored

Dr. Irvine H. Page, emeritus director of research and senior consultant of the Cleveland Clinic Foundation, was the first winner of the Dr. Rodman E. Sheen and Thomas G. Sheen Award, established to honor "the outstanding doctor of medical science in the United States for each year." The award was a plaque and $10,000 cash in recognition of his scientific research, especially in the fields of hypertension and other cardiovascular diseases. The award was established by the will of Thomas G. Sheen, Atlantic City, N. J., businessman, and was named

for Sheen and his younger brother, a physician whose medical career was cut short by an accident and illness.

Ohioan's Plaque Honored

A plaque depicting the Aesculapean staff and serpent, traditional symbol of the medical profession, was presented to the American Medical Association in San Francisco. The striking and beautifully hand lettered plaque was made by Dr. Victor C. Laughlin, of Cleveland. It was presented by Dr. John H. Budd, chairman of the Ohio delegation to the AMA, on behalf of Dr. Laughlin, the Academy of Medicine of Cleveland, and the Ohio State Medical Association.

Dr. Dwight L. Wilbur, AMA President, accepted the gift in behalf of the AMA. The plaque is destined for permanent display at the AMA Headquarters in Chicago.

Dr. Laughlin is an amateur sculptor and artist, and the plaque is part of research he has done on the historic origins and backgrounds of the Aesculapean staff with its single serpent, and the caduceus, or staff of Hermes, with its two serpents and the outstretched wings of Mercury.

The plaque was displayed at the Ohio State Medical Association Annual Meeting in Cincinnati as one of the exhibits.

As a further result of his research, Dr. Laughlin has written articles on this subject and his papers are now considered authoritative reference sources by the AMA archivist in answering inquiries on medical symbols.

Progress on Ohio's Resolutions

A number of resolutions introduced by the Ohio delegation made unusual progress in proceedings of the AMA House of Delegates. Following are summaries of Ohio's proposals and actions of the House.

Qualified Advisors for HEW

The Ohio State Medical Association's Resolution No. 25, as shown in the 1968 OSMA House of Delegates Proceedings, became AMA Resolution 36. The resolution urging recognition of a stronger voice on the part of practicing physicians in federal health, education, and welfare plans was approved in principle by the House of Delegates, with the exception of personal reference to the Secretary of HEW.

The resolution as approved by the House reads as follows:

"Whereas, The private practicing physicians are the best qualified group in matters pertaining to health services; therefore be it

"Resolved, That the American Medical Association request the Secretary of Health, Education, and Welfare to continue to solicit the advice and counsel of those practicing physicians designated by their medical associations at the local, state, and national level, in formulating future plans and programs and in modifying existing programs, in order to provide the best quality health care to the people of the United States."

Cincinnati Physician Was Named AMA Vice-President in 1940

The election of an Ohioan as Vice-President of the American Medical Association is a reminder that another physician of this State served in that high office.

Dr. Parke G. Smith, Cincinnati, was named Vice-President of the AMA at the New York Annual Session, June 10-14, 1940. Dr. Smith, now retired from active practice, was Immediate Past President of the Ohio State Medical Association at the time, having served as President for the 1939-1940 term of office.

Nonmedical Control of Practice

Ohio's resolution 26 which became AMA resolution 37, entitled "Nonmedical Controlled Practice of Medicine" was considered by the Reference Committee with two other resolutions of similar intent.

The approved substitute resolution recommended by the Reference Committee and amended on the floor of the House reads as follows:

"Resolved, That the American Medical Association continue to espouse the private, fee-for-service practice of medicine; and be it further

"Resolved, That the AMA strongly disapproves of the provision of funds by the federal government for subsidizing of any one form of medical practice."

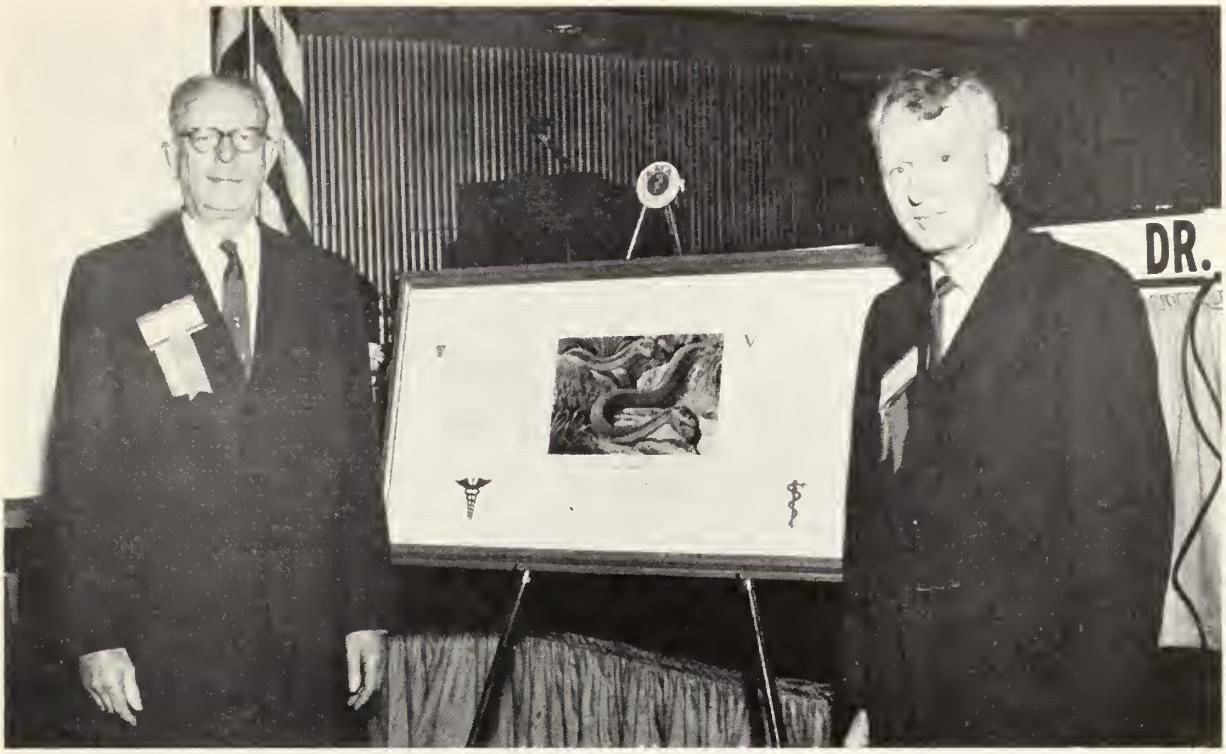
Council on Medical Education

Ohio presented its resolution No. 6 which became AMA resolution 38 calling for a more equitable representation on the AMA Council on Medical Education of physicians who work in nonuniversity affiliated hospital training programs.

The Reference Committee restated a previous policy of the House of Delegates on this subject and recommended a substitute resolution which carries out the intent of the original resolution.

The Reference Committee's recommendation, approved by the House of Delegates, reads as follows:

"Resolution 38, introduced by the Ohio delegation, reflects the concern of the Ohio delegation with the maintenance of effective programs of graduate medical education in hospitals not affiliated with universities. The position of the House of Delegates



American Medical Association President Dwight L. Wilbur, left, accepted on behalf of the AMA the Aesculapean plaque presented by Dr. John H. Budd, chairman of the Ohio delegation, at the final session of the House of Delegates. The plaque is the work of Dr. Victor C. Laughlin, of Cleveland.

in this respect is clearly stated in the 'Essentials of an Approved Internship' as follows:

" 'Affiliation of a hospital with a medical school is not a requirement for internship approval. Such a restruction is neither desirable nor practical, since the national need for internship positions cannot be met by affiliated hospitals alone. There is abundant opportunity for private hospitals that are not affiliated with medical schools to develop outstanding intern training programs, and many nonaffiliated community hospitals provide the varieties of educational environments desired by significant numbers of graduates of American medical schools.'

"Your Reference Committee believes that the intent of this Resolution would be better served if the following Resolve were substituted:

" 'Resolved, that the House of Delegates urge the Board of Trustees in its selection of nominees for the Council on Medical Education to give full recognition to the importance of nonuniversity affiliated hospitals in providing effective educational experience.' "

Osteopathic Physicians

The AMA House of Delegates moved a step forward in the relationship of osteopathy and the medical profession, and specifically referred to a 1965 OSMA resolution on this topic.

Ohio's original resolution (Amended Resolution 7 in the 1965 OSMA House of Delegates proceedings) requested the AMA House "to instruct the Council on Medical Education to develop a method whereby qualifications of osteopathic physicians who are willing to subscribe to the principles of medical ethics of the American Medical Association and who express the wish to join a component county medical society, may be evaluated in order to determine eligibility for intern and residency training in AMA approved hospital programs, without jeopardizing the hospital's accreditation status."

Michigan introduced a resolution similar to the Ohio resolution at this year's convention. The reference committee expressed disappointment in the lack of progress indicated by the AMA Board of Trustees report on the subject. The reference committee's concluding recommendation on this subject, approved by the House of Delegates, reads as follows:

"Your Reference Committee therefore recommends that Report F be accepted for information and that Resolution 32 be referred to the Board of Trustees and the Council on Medical Education with the recommendation that it be considered as a part of an overall program aimed at the full amalgamation of osteopathy with medicine, and that regular reports of progress toward this goal be made to the House of

Delegates beginning with the Clinical Session in 1968."

Citizen MD Graduates of Foreign Schools

Progress was made in regard to establishing clear-cut policies in regard to participation in hospital programs of U. S. citizen graduates of foreign medical schools, even though Ohio's resolution on this subject was not adopted.

AMA Resolution 25 presented by the Ohio delegation was voted down on recommendation of the Reference Committee which considered it along with a report of the Board of Trustees on the same subject. The Reference Committee concurred in a recommendation of the AMA Committee on Health Manpower and the AMA Council on Medical Education "that a new Commission be established outside of government to coordinate fully all of the issues and activities involving foreign medical graduates." The Council on Health Manpower was directed to take the steps necessary to complete plans for the organization and financial support of the Commission.

Prepayment Review Committees

Ohio's Resolution, "Amendments to the Guidelines for Establishing Medical Society Review Committees," a report prepared by the AMA Committee on Insurance Prepayment Plans, was approved by the House of Delegates.

The resolution reiterated the responsibilities of review committees in regard to adjudication and long range education. It pointed out that such committees are not authorized to "negotiate" in regard to physicians fees.

Economy Measure

Ohio made progress on its resolution calling for financial economy in regard to certain policies and procedures of the AMA. Specifically AMA Resolution 17 requested establishment of a policy whereby future interim sessions would be held in Chicago, thereby economizing on travel and other expenses of the AMA staff; a reduction in social activities financed by the AMA; and revisions in the structure of AMA Councils, committees, etc.

The Reference Committee retained the intent and spirit in regard to financial economies, but modified the part of the original proposal in regard to the interim sessions.

The substitute resolution, recommended by the committee, and passed by the House of Delegates reads as follows:

"Resolved, That this House of Delegates take positive action to encourage reduction of the expenditures of this Association by the following:

"1. By requesting the Board of Trustees to continue to take action to reduce, to the extent possible, the extraneous activities financed in whole or in part by the AMA at all meetings of the House of Delegates, the several councils, committees, seminars and other meetings.

"2. By requesting the Board of Trustees to continue to make recommendations as to the consolidation or even abolishment of councils and committees whose reason for creation may no longer exist, or for whose mission the AMA has served as a catalytic developer and for which other agencies have now recognized the responsibility and are able to assume the financial obligation of the program, and be it further

"Resolved, That the House of Delegates reiterate its support for the continuation of the existing practice of holding the Clinical Conventions of the House of Delegates in conjunction with the meeting of the Scientific Assembly."

AMA Councils and Committees

Ohio's Resolution, entitled "Supervision of AMA Councils and Committees by the Board of Trustees," was modified by the reference committee, but the intent of the original resolution was retained. The substitute resolution approved by the House of Delegates reads as follows:

"Resolved, That the House of Delegates request the Board of Trustees, under its authority as established by the Constitution and Bylaws of the Association, to continue to exercise supervision over the activities of all councils and committees of the Association and of the Headquarters Staff of the AMA.

Other Actions

The House approved a resolution directing the Council on Constitution and Bylaws to draw up amendments toward further elimination of discrimination in election of members on the part of state associations.

In addition to Ohio's resolutions on the subject, numerous actions were taken in regard to the relationship between the medical profession and governmental agencies dealing in medical and health care matters.

The House reaffirmed "previous policies requesting that all efforts be made to eliminate recertification requirements under" Medicare and called on the congress "to amend the laws and regulations pertaining to PL 89-97 to specifically permit direct billing to all Title 19 recipients."

The House also resolved that "The Board . . . take appropriate action seeking the establishment of a separate Department of Health headed by a Doctor of Medicine."

A resolution proposed that congress establish within its control a "Committee on Rules and



Dr. Irvine H. Page, left, Cleveland, became the first doctor to be honored with the new annual Sheen Award in recognition of his outstanding and dedicated service to medicine. Dr. Milford O. Rouse, 1967-1968 American Medical Association President is making the presentation at the 1968 Annual Convention in San Francisco.

Policies of Federal Administrative Agencies" whose "responsibility it will be to review rules and policies promulgated by federal administrative agencies to determine that (they) are in accord with the legislative intent of the congress." It was adopted in principle and referred to the Board and the Council on Legislative Activities.

The House voted to continue the AMA's own educational program on smoking and health rather than become a formal sponsoring member of the Interagency Council on Smoking and Health.

The House referred to the Council on Medical Education a resolution protesting proposed changes in the Essentials for Accredited Schools of Medical Technology by the American Association of Clinical Pathologists which would eliminate approved schools of medical technology on the basis of size; and referred to the Board a resolution that osteopathic physicians be admitted to AMA approved hospital internship and residency programs under certain circumstances.

Also referred to the Board was a resolution to establish a joint commission on accreditation of nursing schools, with participation by the AMA, American Hospital Association, the American Nurses' Association, and National League for Nursing.

A Judicial Council report was adopted on "Ethical Guidelines for Organ Transplantation." (See complete text elsewhere in this issue.)

A Council on Medical Service report on automated multiphasic screening, approved by the House, pointed out that tests used in "a multiphasic screening program should be relatively simple to administer, easy to interpret, relatively inexpensive and require little time to perform." All such screening programs should be subjected to the five criteria suggested by the former National Commission on Chronic Illness: Reliability; validity; yield of information; cost; and acceptance by physicians, individual laymen and the community.

The House adopted a Board report recommending AMA support for the use of the Slow-Moving Vehicle Emblem developed by Ohio State University for all vehicles, tractors, construction equipment or horse-drawn vehicles moving less than 25 miles per hour, and now being used in Ohio. The House

voted to "participate in a program of planning and action with other organizations concerned with architectural barriers to the handicapped."

It resolved to continue AMA "efforts to safeguard and inform the medical profession and the public with respect to the treatment of obesity."

It also referred to the AMA's policy on chiropractic and urged state and local medical societies "to formally adopt the AMA Policy Statement on Chiropractic, or a somewhat similar expression."

The House approved a Board report stating that communication with hospital Boards of Trustees has been supplemented by increasing the circulation of the AMA's publication "Medical Staff-in-Action" to include physician-hospital relationship committees of state and local medical societies and of state and local hospital associations.

Regarding use of paramedical personnel, the House recommended to the Joint Commission on Accreditation of Hospitals, the American Hospital Association, and its state and local chapters and to hospitals and other related facilities "that the practice of medicine . . . be preserved as the responsibility of the physician and that paramedical personnel not be placed in the position of practicing medicine whether by consent, design or contract."

Financial Matters

A report warned "that a substantial increase in the budget of the AMA will be necessary within the next few years if the AMA is to fulfill its mission. Major items such as the cost of printing and paper are rising sharply and the pressure of inflation has greatly increased the cost of providing AMA's normal services."

The report stated that the tax effect of the IRS regulations is not known at this time on the AMA's gross income of approximately $13 million annually from advertising in its publications before deduction of costs and allowable expenses.

The report pointed out that the Board "is not recommending an increase in dues . . . at this time, because it wants additional information regarding various matters affecting our financial situation before reaching such a decision."

Tribute to Deceased Members

The House of Delegates paid tribute to its recently deceased former members, among them Dr. Paul A. Davis, of Akron, who died on August 4, 1967. Dr. Davis had a long record of service in medical organization work, including many terms in the AMA House of Delegates.

Ohio's Delegation

Ohio was represented in the AMA House of Delegates by the following physicians: John H. Budd, Cleveland; Philip B. Hardymon, Columbus; Theodore L. Light, Dayton; Carl A. Lincke, Carrollton; Richard L. Meiling, Columbus; Frederick P. Osgood, Toledo; George W. Petznick, Cleveland; Charles A. Sebastian, Cincinnati; and Robert E. Tschantz, Canton.

Alternate Delegates who also attended the meeting are: Kenneth D. Arn, Dayton; Henry A. Crawford, Cleveland; Harry K. Hines, Cincinnati; Robert S. Martin, Zanesville; Lawrence C. Meredith, Elyria; Horatio T. Pease, Wadsworth; Frank Rawling, Toledo; John P. Robechek, Cleveland; Robert N. Smith, Toledo; and Frank H. Mayfield, Cincinnati.

Among other Ohio physicians who attended House of Delegates functions were Dr. Robert L. Howard, OSMA Immediate Past President, and Dr. Edwin R. Westbrook, Councilor of the Sixth District, and H. William Porterfield, Columbus, Chairman, OSMA Committee on Government Medical Care Programs.

Election

Dr. Dwight L. Wilbur, of San Francisco, was installed as President of the AMA to succeed Dr. Milford O. Rouse.

Gerald D. Dorman, New York, was named President-Elect.

Walter C. Bornemeier, Illinois, and Russell B. Roth, Pennsylvania, were re-elected by acclamation to their respective posts as Speaker and Vice-Speaker of the House.

Four trustees were elected: L. O. Simenstad, Wisconsin, succeeding himself; and Raymond T. Holden, Washington, D. C.; John M. Chenault, Alabama; and John R. Kernodle, North Carolina.

Walter H. Judd, Washington, D. C., was elected by acclamation to succeed himself on the Judicial Council.

Robert B. Hunter, Washington, was elected to the Council on Constitution and Bylaws.

Francis L. Land, Washington, D. C., and E. Bryce Robinson, Jr., Alabama, were re-elected by acclamation to the Council on Medical Education.

Burns A. Dobbins, Florida, and Drew M. Petersen, Utah, were re-elected by acclamation to the Council on Medical Service; and W. B. Hildebrand, Wisconsin, was elected to fill the remaining two-year term vacated by John R. Kernodle, who was elected to the Board.

For Organ Transplantation

FOLLOWING is the text of "Ethical Guidelines for Organ Transplantation," a statement approved by the House of Delegates of the American Medical Association at the San Francisco Annual Convention. The guidelines originated as Report B of the AMA Judicial Council, and underwent slight revision in House Reference Committee E, under chairmanship of Dr. Richard L. Meiling, of Columbus. Following is the revised text, recommended by the committee and approved by the House of Delegates.

* * *

"It should be apparent that no stigma is attached to the performance of human experiments per se; disgrace and infamy can arise only through its misuse. The moral obligation of performing all human experiments, with due regard to the sensibility, welfare, and safety of the subject, must not be violated. As phrased by Claude Bernard in 1856, 'Christian morals forbid only one thing, doing ill to one's neighbor.' So, among experiments that may be tried on man, those that can only do harm are forbidden, those that are harmless are permissible, and those that may do good are obligatory." *S. S. Kety*

The medical profession, in its never-ending search for ways to save human life, relieve suffering and improve health, has always been motivated and guided by the principles expressed in the above quotation. To achieve these goals, it has recognized that proper standards must be established and followed in clinical investigation and experimentation involving human beings.

In 1946, the American Medical Association succinctly listed three ethical guidelines to be followed in human experimentation in order to conform to medical ethics: (1) voluntary consent must be obtained from the person on whom the experiment is to be performed; (2) the dangers of each experiment must have been previously investigated by animal experimentation; and (3) the experiment must be performed under proper medical protection and management.

In 1964, the World Medical Association adopted the Declaration of Helsinki, which was later endorsed by the American Medical Association. The Declaration emphasizes "freely given consent" and differentiates between clinical research combined with professional care and nontherapeutic clinical research.

In 1966, the American Medical Association adopted a longer statement—"Ethical Guidelines for Clinical Investigation." In part, these guidelines state:

"In clinical investigation primarily for treatment—

"A. The physician must recognize that the physician-patient relationship exists and that he is expected to exercise his professional judgment and skill in the best interest of the patient.

"B. Voluntary consent must be obtained from the patient, or from his legally authorized representative if the patient lacks the capacity to consent, following: Disclosure that the physician intends to use an investigational drug or experimental procedure; a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits; an offer to answer any inquiries concerning the drug or procedure; and, a disclosure of alternative drugs or procedures that may be available."

The Principles of Medical Ethics and these several statements have provided broad guidelines during the period when transplants of major body organs were first performed. In the opinion of the Judicial Council these principles continue to be valid.

Now, theologians, lawyers and other public spirited persons, as well as physicians, are discussing with deep concern the many new questions raised by the transplantation of vital organs. Man participates in these procedures: he is the patient in them; or he performs them. All mankind is the ultimate beneficiary of them.

A man, in the final analysis, must make a decision whether to permit or to perform a transplantation procedure. The decision must be a reasoned, intellectual decision, not an emotional decision. As medical science advances, and as technological skill increases, the ethical questions involved may become increasingly complex and difficult.

The Judical Council, therefore, commends discussions of the moral, ethical, legal, social, and other aspects of clinical investigation, experimentation, and organ transplantation in human beings. It commends all efforts which encourage respect for the

dignity of man, and which seek to sensitize man's ethical conscience.

The Judicial Council of the AMA offers the following statement for guidance of physicians as they seek to maintain the highest level of ethical conduct in their practice.

1. In all professional relationships between a physician and his patient, the physician's primary concern must be the health of his patient. He owes the patient his primary allegiance. This concern and allegiance must be preserved in all medical procedures, including those which involve the transplantation of an organ from one person to another where both donor and recipient are patients. Care must, therefore, be taken to protect the rights of both the donor and the recipient, and no physician may assume a responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

2. A prospective organ transplant offers no justification for relaxation of the usual standards of medical care. The physician should provide his patient, who may be a prospective organ donor, with that care usually given others being treated for a similar injury or disease.

3. When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests.

4. Full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives is mandatory. The physician should be objective in discussing the procedure, in disclosing known risks and possible hazards, and in advising him of the alternative procedures available. The physician should not encourage expectations beyond those which the circumstances justify. The physician's interest in advancing scientific knowledge must always be secondary to his primary concern for the patient.

5. Transplant procedures of body organs should be undertaken (a) only by physicians who possess special medical knowledge and technical competence developed through special training, study, and laboratory experience and practice, and (b) in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

6. Transplantation of body organs should be undertaken only after careful evaluation of the availability and effectiveness of other possible therapy.

7. Medicine recognizes that organ transplants are newsworthy and that the public is entitled to be correctly informed about them. Normally, a scientific report of the procedures should first be made to the medical profession for review and evaluation. When dramatic aspects of medical advances prevent adherence to accepted procedures, objective, factual, and discreet public reports to the communications media may be made by a properly authorized physician, but should be followed as soon as possible by full scientific reports to the profession.

In organ transplantation procedures, the right of privacy of the parties to the procedures must be respected. Without their authorization to disclose their identity the physician is limited to an impersonal discussion of the procedure.

Reporting of medical and surgical procedures should always be objective and factual. Such reporting will also preserve and enhance the stature of the medical profession and its service to mankind.

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1. Stern, S.B.; Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing information)

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Woman's Auxiliary Highlights . . .

A Column Conducted in Behalf of the Woman's Auxiliary to the OSMA
By Mrs. Robert E. Pumphrey, Chairman, Publicity Committee
3055 Big Hill Road, Dayton 45419

Report of the San Francisco Annual Convention

IT SEEMS ONLY FITTING that this highlight of the 1967-1968 season — the national convention Presided over by Ohio's Mrs. Karl F. Ritter — should be reported in that unique style known well to readers of this column. Mrs. S. L. Meltzer, President-Elect of the Ohio Auxiliary, and former publicity chairman, gave her impressions of the meeting in the following letter written while she was still on the West Coast.

* * *

Mrs. Robert E. Pumphrey
Dear Audrey:

Where do I begin? I'm writing this from Los Angeles, but my mind is back in that intriguing city of San Francisco and that really outstanding forty-fifth Annual Convention of the Woman's Auxiliary to the American Medical Association. In front of me is my notebook and my scribbling stares up at me and dares me to decipher the voluminous notes. (I'm using a borrowed typewriter that, at times, seems to have mule-like tendencies!) I know you don't expect me to write another book at this point. So why don't I limit myself, in a sense to the highlights — the "focal" points?

As far as we in Ohio are concerned, of course the focal point, without question, centered around the incredible Mrs. Karl F. Ritter, who presided over the convention as President of the National Auxiliary. I keep remembering the tremendous job she did — her poise, her know-how, her facility of expression, her graciousness and her ability to create a very special and significant atmosphere. And yes, I even remember the stool on which she had to stand on the podium to reach the microphone more effectively! A first for an auxiliary president, I'm sure. She kidded about that herself, so I'm sure she won't mind my mentioning it. . . .

Highlight Number One — Sunday evening, June 16 the Mural-California room at the St. Francis Hotel and the reception honoring Mrs. Ritter and Mrs. C. C. Long, President-Elect. Forgive the play on words, Audrey, but Gerby really was "in the pink" that night — gowned in a lucious pink with matching accessories and the First Lady herself in the pink of condition. And know something? By the end of the convention, she was still her delightful, unruffled self!

Highlight Number Two — The Ohio breakfast on Monday June 17 - the traditional getting together the first morning of convention (would you believe it took place at 7:30 A.M. ?) Twenty-eight members from the Buckeye State were there — bright-eyed in spite of the early hour, talkative (as always), enthusiastic (ditto) and at each plate was a beautiful and fragrant red carnation, courtesy of auxiliaries of Alliance, Ohio — "Carnation City of the World." Also from that group came a breath-taking centerpiece of red carnations for presentation to our National President. And quite typically, Gerby proved her loyalty to her home state that first morning by replacing an exquisite yellow orchid she was wearing with the vivid red of her state flower . . . Quickly I must add, she didn't throw the orchid away; Vi Colombi was designated "keeper of the orchid" until the session was over.

Highlight Number Three — The opening session of the House of Delegates and Mrs. Malachi W. Sloan (chairman of delegates and Ohio President) at Roll Call uttering the resounding "Ohio — 19 delegates" which translated meant our full quota! The business sessions were held in the Colonial Room of the St. Francis Hotel, with its magnificent white and gold decor, the resplendent "boxes" encircling the upper tier, the huge chandeliers whose prisms caught and reflected dancing beams of light. There were 321 delegates present that opening morning; only one state lacks an auxiliary — New Mexico — but it does have members-at-large.

On the agenda that first business session was the president's report which was something to hear and to relish. (I wish every auxiliary member the length and breadth of this land could have heard that resume of auxiliary activities; it would certainly erase any doubts that some might have of whether or not we accomplish anything worthwhile!) Gerby briefed her House of Delegates on the 1967-68 activities in Community Health, Legislation, and Health Careers (there was an increase of $50,000 over last year for this important project, bringing the total amount this past year to a figure that constituted the largest amount ever contributed by the auxiliary) . . . Doesn't that

make you want to stand up and shout? Doesn't that give you a rewarding sense of accomplishment? Mrs. Ritter told of some 341,000 pounds of pharmaceutical supplies that had been provided for International Health and some 25,000 medical and surgical items. Of course there were many, many other important projects she talked about. Remember — I'm only highlighting! But I must not fail to include Gerby's comment on her unusual collection of cook books (given to her, I gather, from here, there, and everywhere): "I shall soon be happily cooking my way to complacent corpulence" . . .

Highlight Number Four — For the first time an outside speaker was presented at the opening session of the National Auxiliary convention. The dynamic talk by Mr. Philip Lesly, counsel on public relations and communications to the AMA, whose topic, "How Can We Prevent Being Defeated By Success?" was undoubtedly one of the most meaningful talks I have ever had the privilege of hearing. He warned that medicine is no longer a cloistered science, but is in the public limelight, for better or for worse. "To be broadcasting to people," he said, " you must be tuned in on their wave length . . .you must become motivators, makers of public opinion . . . one of the greatest forces in America are you women . . .explain, educate, answer questions . . . auxiliary members should take part in politics . . ." Mr. Lesly went on to point out that everything today is more complex, that the problem is how to create, live with, and master change. He discussed the vital benefits of objectivity, and so very much more. He was terrific!

Highlight Number Five — The presentation, at Monday's luncheon, of a check in the amount of $389,824.64 by Mrs. Ritter to Dr. Gerald D. Dorman, vice-chairman of AMA-ERF and now AMA President. Since 1953, Dr. Dorman said, some $15 million has been given to medical education by the profession. He then presented awards to Gerby Ritter and her national AMA-ERF chairman, Mrs. Chester Young, "for outstanding work." And then — guess what? Ohio received an Award of Merit for the largest contribution per capita in the North Central Region! (The award is a truly magnificent plaque which, I believe, will be given a special place of honor at our Central Office.) I would love to have seen the faces of Ginny Steele and Polly Weiland when they received the news! As if that award wasn't enough to crow about, the County Achievement Award given in the 26 to 60 membership category was won by Tuscarawas County. Yeah, Ohio! And speaking of Tuscarawas (golly, just how many times is it now that it has won national recognition???) Mary Louise Van Epps was AMA-ERF regional chairman this year and I DID get to see the delight on her face . . .

Highlight Number Six — At the Tuesday morning session on June 18, the reports of State Auxiliaries in the North Central region were moderated by another outstanding Ohio past president, Mrs. John D. Dickie of Lucas County who served this past year as a National Regional Vice-President. Mrs. Paul Sauvageot, Presidential Delegate from Ohio and immediate past president, gave her report on Ohio activities. Featured was the "Boutique" for psychiatric patients, operated by the Cuyahoga County auxiliary. (This fine project has been written up in the Auxiliary Highlights column in some detail.) Ludel knows how to "communicate" and her three minute report was delivered clearly, concisely, interestingly . . . This bundle of energy from Akron has served on the editorial staff of *MD's Wife* the past year. And now hail to the new national communications chairman — who else but Ludel? We're so proud and pleased! Congratulations Madame Sauvageot . . .

Highlight Number Seven — Tuesday's luncheon honored leaders of National women's volunteer organizations who are members of the auxiliary and featured, as speaker Dr. Henrik L. Blum, Clinical Professor of Community Health Planning, School of Public Health, University of California (Berkeley). His somewhat grim and realistic talk "Program Planning and Implementation" packed a wallop, to say the least. He discussed the critical status of our country's health, of the major problems confronting us in Genetics Environments and the Habits of People. He urged a careful look at what really causes ill health — that too much of it is caused by an affluent

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THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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society. He proceeded to discuss possible and practical remedial measures — not easy ones, mind you, but well within the realm of possibility.

Highlight Number Eight — Tuesday afternoon's Communications Program. Mrs. C. Rodney Stoltz, chairman talked on "As Others See Us." Mrs. John Wagner, editor, *MD's Wife,* and our own Ludel Sauvageot discussed "Putting Our Best Foot Forward." "Are we giving lip service or do we truly believe?" Ludel asked. "NOT only words but attitudes must be well chosen," she said. "Keep informed so that you are able to answer adverse criticism . . . the worst way to answer is emotionally . . . if you don't know, say so; there's no harm in admitting it . . . tell story so well people won't want to generalize . . . if we put our best foot forward consciously and constantly, we can make a lasting contribution . . ."

Highlight Number Nine — The well conducted installation of new officers and directors by Mrs. Mason G. Lawson, a past national president, on Wednesday morning, June 19. Mrs. C. C. Long of Arkansas was installed as National President and Mrs. John Chenault, President-Elect. Mrs. Long's theme for 1968-69 is "Accent on Youth."

Highlight Number Ten — The extraordinary number of lovely gifts, both from individuals and groups, which were presented to Gerby, began with the magnificently beautiful jade swan, dating back to the Ming Dynasty and virtually a museum piece, from her national board of directors. Equally beautiful was the gold and silver pen set from her Ohio Auxiliary — a precious treasure for those "at home" hours at her desk. From Gerby's own Allen County there was a delectable cashmere sweater for those very special evening occasions — and the Allen County Medical Society, in the person of Dr. L. W. Like, presented an armful of beautiful, long stemmed carnations. A most unusual tribute in the form of an attractive, inscribed tray came from the Woman's Auxiliary to the National Medical Association. I know I am overlooking other lovely presentations but I just didn't get them all down! And of course there were leis from Hawaii for Gerby, Mrs. Long, and Mrs. Chenault.

Highlight Number Eleven — This item deserves its own special place because it was so extra-special and another first. Following the auxiliary installation, Dr. Karl Ritter performed his own installation high in the upper tier of one of the gold, opera-like boxes. A pin, especially made for the occasion, was sympathetically and happily given to the husband of the new auxiliary president — Dr. C. C. Long. The "outgoing" husband murmured words of encouragement to the "incoming" husband, if you know what I mean! And along with the words, Karl also presented Dr. Long with a gift of a little hot water bottle! I can't leave Gerby's charming spouse without mentioning his bravery "beyond the call of duty." Wednesday night he escorted eight of us unattached females to dinner. (And you know — I think he really enjoyed being the only man in the crowd . . .) Thank you, dear Dr. Ritter.

Highlight Number Twelve — The proposed amendment for a two dollar increase in National dues, effective for the 1969-1970 auxiliary year passed with a resounding vote of confidence by the House of Delegates. It seemed there was little doubt that the great majority of the delegates realized the absolute need for the increase. We don't have to be told how costs have spiraled. An organization that boasts a membership of 90,000 must have the financial means to carry on its many faceted and vital program. I have said it before, and I say it again — there is no greater privilege than that of being an Auxiliary member.

Well, there it is, Audrey. I started to say "in a nutshell" but it's hardly that, I guess! And yet, I really only skimmed the surface. There was so much that was worthwhile and helpful and inspirational. There were 1,043 registered at convention. A tidy number, I'd say! Going to a National Convention is an experience, believe me. I know mention of cable cars, the top of the Mark, Fisherman's Wharf, Telegraph Hill and the Coit Tower, Chinatown, the new Japanese Center, Gumps, Hippies, Union Square, etc., etc., are not, strictly speaking, part of convention and I guess not "properly" to be dragged in, yet how can I speak of San Francisco and not give them bare mention???

Ruth K. Meltzer

Grant from Heart Institute Promotes Cincinnati Research Project

University of Cincinnati Medical Center physicians at Cincinnati General and Veterans Administration Hospitals have joined forces with physicians at the Jewish Hospital to search for the most effective medication to prevent heart irregularities after an acute heart attack.

The project has received a $66,073 grant for a three-year period from the National Heart Institute. Researchers will determine the effectiveness of quinidine in preventing cardiac arrhythmias. Patients volunteering for the research have acute myocardial infarction.

Dr. Saul S. Bloomfield, UC assistant professor of medicine and pharmacology, is principal investigator. Assisting him are Drs. Noble O. Fowler, director, Cardiovascular Research Laboratory, Thomas E. Gaffney, director, division of clinical pharmacology, and Te-Chuan Chou, associate professor of medicine, all at UC, and Dr. Gene F. Conway, chief, VA cardiology section.

Ad Astra

Lyman A. Adair, M. D., Wooster; University of Michigan Medical School, 1921; aged 75; died June 15; member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in the Wooster community, Dr. Adair also served as Wayne County coroner for many years and as county health commissioner. He was also for many years physician and surgeon for the Baltimore & Ohio Railroad. Among affiliations, he was a member of the Ebenezer Lodge, the Presbyterian Church, the Walton League, Elks Lodge, the Civil War Club, and the Historical Society. Among survivors are his widow, two daughters, two sisters, and a brother.

Charles John Bondley, M. D., Belle Center; Eclectic Medical College, Cincinnati, 1903; aged 91; died June 11; member of the Ohio State Medical Association and the American Medical Association. Except for an early practice in West Virginia, Dr. Bondley served all of his professional career in Logan County, first having his office in Big Springs and from 1924 in Belle Center. He was a veteran of the Spanish-American War and a member of the VFW and the American Legion. Affiliations included membership in several outdoor and sporting organizations, several Masonic bodies, and the Presbyterian Church. Among survivors are a son and two daughters.

Donald Frederick Bowers, M. D., Columbus; Ohio State University College of Medicine, 1926; aged 67; died June 10; member of the Ohio State Medical Association, the American Medical Association, American Rheumatism Association, the American Diabetes Association, and American Heart Association. A prominent practicing physician in Columbus for many years, Dr. Bowers was for ten years a member of the State Medical Board of Ohio, and was a member and chairman of the State Board of Cosmetology. In the medical education field, he held an appointment as assistant professor of clinical medicine at Ohio State University. Dr. Bowers held high honors in Masonry; was a past potentate of Aladdin Shrine; past master of his Blue Lodge; past director of the Royal Order of Jesters. He was a member of the Episcopal Church, served on the County Welfare Board, was a past president of the Kiwanis Club, was a member of the Last Man's Club, the Maennerchor, and the American Legion. He is survived by his widow, a daughter, a son, his father, and a sister.

Clyde William Dawson, M. D., Columbus; Ohio State University College of Medicine, 1929; aged 64; died June 9; member of the Ohio State Medical Association, the American Medical Association, the Clinical Orthopaedic Society, the American Academy of Orthopaedic Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Orthopaedic Surgery. A practicing physician for some 30 years in Columbus, Dr. Dawson was associate professor of orthopaedic surgery at Ohio State University; was active in several Masonic bodies, and was a member of the Community Church. He is survived by his widow, two sons, two daughters, a brother, and a sister.

Morris D. Goldberg, M. D., Columbus; Ohio State University College of Medicine, 1920; aged 73; died July 3; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for many years in Columbus, Dr. Goldberg specialized in the eye, ear, nose, and throat field. He was on the teaching staff of the OSU College of Medicine, was a past president of the Excelsior Club, a past president of B'nai B'rith, and a member of Temple Israel. Among survivors are his widow, and a son, Dr. Jack L. Goldberg, also of Columbus; also a sister.

Richard Clinton Hiestand, M. D., Springfield; University of Cincinnati College of Medicine, 1931; aged 63; died June 5; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics. A native of Springfield, Dr. Hiestand served all of his professional career there, specializing in pediatrics. He is survived by his widow and a son.

Charles E. Hauser, M. D., Monroe and Cincinnati; Medical College of Ohio, Cincinnati, 1903; aged 86; died June 27; member of the Ohio State Medical Association and the American Medical Association. After an active career of 50 years of medical practice in Cincinnati, Dr. Hauser retired in 1954. His specialty was obstetrics and gynecology. He was a past president of the Academy of Medicine of Cincinnati, a past president of the Cincinnati Obstetric and Gynecology Society, trustee of Hospital Care Corporation and former secretary to its medical advisory committee. During World War II he served on the OSMA War Preparedness Committee and the Ohio

Procurement and Assignment Committee for medical personnel. Numerous other affiliations included membership in the Presbyterian Church. Surviving are his widow and two sons, Dr. Charles U. Hauser, Hamilton, and Dr. John W. Hauser, of Cincinnati.

Gerald B. Hurd, M. D., Yalaha, Florida; Johns Hopkins University School of Medicine, 1928; aged 66; died June 22; member of the Ohio State Medical Association, the American Medical Association and the American College of Obstetricians and Gynecologists; diplomate of the American Board of Obstetrics and Gynecology. Dr. Hurd was a native of Hiram and a practicing physician for many years in Cleveland. He was a past president of the Cleveland Society of Obstetrics and Gynecology, and a trustee of Hiram College. Among survivors are his widow, two sons, his mother, and two brothers.

Eli Helia Kamm, M. D., Mayfield Heights; Ohio State University College of Medicine, 1944; aged 48; died June 5. A former military medical officer, Dr. Kamm served on active duty during World War II and during the Korean Conflict. He was in general practice with offices in the Warrensville Heights area of Greater Cleveland.

Ben R. Kirkendall, M. D., Marysville and Miami Beach, Florida; Starling Medical College, Columbus, 1905; aged 85; died June 16; member of the Ohio State Medical Association, American Medical Association, American Radium Society, and the American Cancer Society. Dr. Kirkendall practiced medicine for 60 years before his retirement, most of that period in Columbus. Formerly on the faculty of the OSU College of Medicine, he was later named associate professor emeritus. A member of the Masonic Lodge, he is survived by his widow, two sons, and three daughters.

Banjerd Nopjaroonsri, M. D., Youngstown; Faculty of Medicine at Chiengmai Hospital, University of Medical Sciences, Chiengmai, Thailand, 1965; aged 28; died July 9. Dr. Nopjaroonsri, a native of Thailand, was in residency training at North Side Hospital in Youngstown where he had been since 1966. He is survived by his widow.

Helena T. Ratterman, M. D., Cincinnati; University of Cincinnati College of Medicine, 1914; aged 86; died July 2; member of the Ohio State Medical Association and the American Medical Association. A practicing physician of long standing in Cincinnati, Dr. Ratterman was noted for her work in the field of obstetrics. In 1964 she was recipient of the Elizabeth Blackwell Medal, bestowed upon her by the American Medical Women's Association.

William Raymond Rogers, M. D., Cincinnati; University of Cincinnati College of Medicine, 1920; aged 76; died June 18; member of the Ohio State

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Medical Association and the American Medical Association. A practicing physician of long standing in Cincinnati. Dr. Rogers was living in retirement in the New Richmond area. Among affiliations he was a member of the Masonic Lodge. His widow and a daughter survive.

Edward Beaty Roller, M. D., Lithopolis; Starling Medical College, Columbus, 1905; aged 89; died June 15; member of the Ohio State Medical Association and the American Medical Association. Despite his age, and the loss of a leg in 1961, Dr. Roller still continued to practice in the Lithopolis community where he had been for some 63 years. He died as the result of a robbery and assault in his home. A leader in community affairs, Dr. Roller was a member of the Presbyterian Church, several Masonic bodies, and the Kiwanis Club. Preceded in death by his wife, he is survived by nieces and nephews.

Ronald LeRoy Ross, M. D., Akron; Western Reserve University School of Medicine, 1920; aged 73; died June 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Ross was a practicing physician of many years standing in the Akron area. Among affiliations, he was a member of the Presbyterian Church and several Masonic bodies. His widow survives.

Sidney Ralph Stone, M. D., Wellington; Western Reserve University School of Medicine, 1932; aged 61; died June 9; member of the Ohio State Medical Association and the American Medical Association. Dr. Stone began practicing in the Lorain County community in 1946 after a five-year military record in World War II during which he attained the rank of colonel in the Medical Corps. Before the war he practiced in Cleveland. Among affiliations, he was a member of the Temple and B'nai B'rith. Survivors include his widow, two sons, a daughter, and three sisters.

Victor Ferman Woldman, M.D., East Cleveland; Western Reserve University School of Medicine, 1928; aged 65; died June 16; former member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology. A life-long resident of the Cleveland area, Dr. Woldman practiced there for about 30 years before his retirement ten years ago. A daughter survives.

Melvin Francis Yeip, M. D., Cleveland; Western Reserve University School of Medicine, 1930; aged 62; died June 22; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A life-long resident of Cleveland, Dr. Yeip served most of his professional career there. During World War II he entered military service with the Navy and was on duty in the Pacific Theater. He was twice president of the Cleveland Catholic Physicians Guild and in 1958 was president of the national Catholic Physicians Guild. Survivors include his widow, three daughters, two sisters, and a brother.

Boleslaw Dominik Zietak, M. D., Cleveland; Medical degree in 1943 from the Polish School of Medicine, relocated in Edinburgh, Scotland; aged 59; died June 2; member of the Ohio State Medical Association, the American Medical Association, American Society of Anesthesiologists, and the International Anesthesia Research Society. A native of Poland, Dr. Zietak served with the Allied Forces during World War II and practiced for a while in England before coming to this country. He was in Chicago from 1949 to 1954 when he moved to Cleveland. Surviving are his widow, two daughters, a son, a brother, and a sister.



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Unique Unit at Western Reserve Deals With the Unusual Child Patient

University Medical Center in Cleveland is now operating a special service in the Children's Unit of Hanna Pavilion, described by officials there as the first of its kind. Patients from ages 6 to 13 who do not respond to customary methods of diagnosis and treatment are referred to the unit by physicians and hospitals. Sicknesses of these patients are usually found to be associated with multiple handicaps, both physical and psychological.

The unit, although located in the psychiatric hospital, is jointly run by the Departments of Pediatrics and Child Psychiatry. As a pilot project set up three years ago to work out new diagnostic methods and teach them to doctors in training, the unit has only 12 patient beds, but the staff includes school teachers, social workers, occupational therapists, psychologists, and child-care workers, as well as physicians.

Officials point out that to avoid a predominance of female workers, most of the child-care workers are young men. When possible a child is admitted to the unit in gradual stages over a two-week period. Emphasis is placed on 24-hour observation of the child and the average stay is about 80 days.

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HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

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in the treatment of

IMPOTENCE

Android®
(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

***"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android
Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

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HIGH POTENCY
Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ... 64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
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Methyl Testosterone ..2.5 mg.
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Ascorbic Acid (Vit. C) .250 mg.
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Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
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***Dose:* 2 tablets daily.**
***Available:* Bottles of 60, 500.**

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REFER TO PDR

also available with ESTROGEN

Android –E
Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride .... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRAINDICATIONS.** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Addenda to Specialty Society and OSMA Section Roster

Following is additional information and corrections in the rosters of Specialty Society Organizations in Ohio and OSMA Specialty Sections as published in the July issue of *The Journal*, pages 875-876.

OSMA Section on Directors of Medical Education — Chairman is Ralph E. Pickett, M. D., Licking County Memorial Hospital, 1320 W. Main St., Newark 43055.

OSMA Section on Radiology — Chairman is Atis Freimanis, M. D., Department of Radiology, University Hospitals, Columbus 43210. (No secretary has been named.)

Ohio Society of Pathologists—Secretary is Robert G. Thomas, M. D., Elyria Memorial Hospital, 630 E. River St., Elyria 44035.

Readers who clipped or copied all or part of the July issue rosters are requested to note these changes. *The Journal* staff regrets any inconvenience or embarrassment caused by errors in the rosters.

Manual on Blood Pressure Recordings Issued in Revised Edition

A completely revised edition of the American Heart Association's manual, "Recommendations for Human Blood Pressure by Sphygmomanometers," now is off the press and available to physicians from their local Heart Associations, or the Ohio State Heart Association, 10 East Town Street, Columbus, Ohio 43215.

The 48 page booklet covers "Equipment for Indirect Measurement of Blood Pressure," "Determination of Blood Pressure in Infants and Children," and "Epidemiological Methods." It also contains an appendix note regarding criteria for diastolic pressure.

The revisions were authorized by AHA's Central Committee for Medical and Community Program and prepared by a special committee of the Association.

Physician Appointments Announced At Case Western Reserve

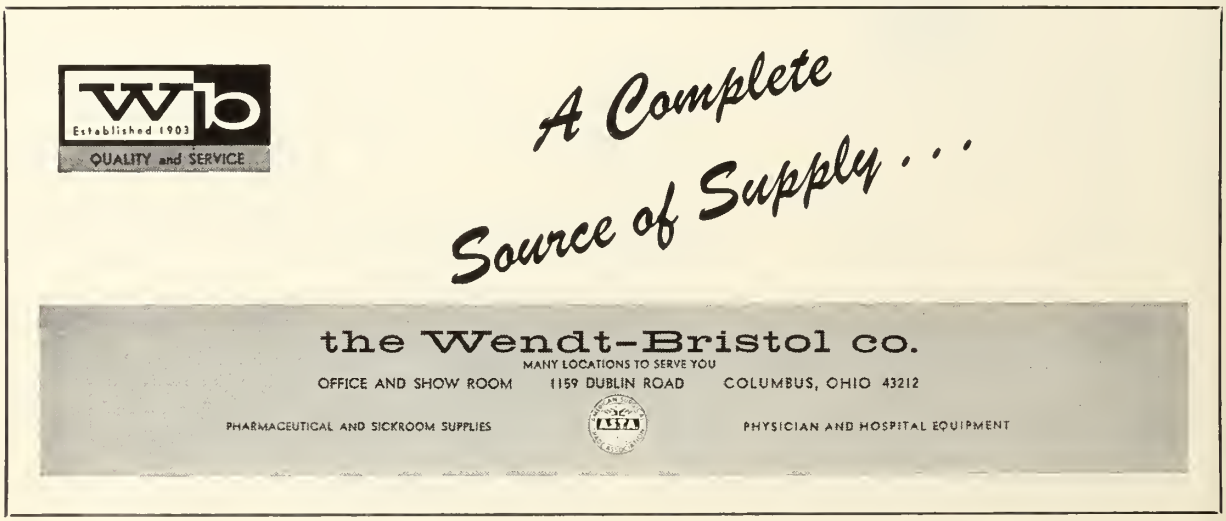
First full professor in the new Department of Biomedical Engineering, jointly sponsored by Case Western Reserve University Schools of Medicine and Engineering, will be Donald S. Gann, M. D., who will be professor of physiology and biomedical engineering, as well as professor of surgery in the Department of Surgery of the medical school. Four other professors were appointed by the School of Medicine; they are Cecil Cooper, Ph. D. and David A. Goldthwait, M. D., biochemistry, Leonard Share, Ph.D., physiology, and Maurice Sachs, M. D., clinical professor of radiology.

Three grants totaling over $50,000 have come to faculty members of the School of Medicine from the National Multiple Sclerosis Society through the Cleveland chapter of the organization.

Associate Professor Rune J. Stjernholm was given $23,571 for a continuation of his studies in biochemistry of the possible relationship of the autoimmune mechanisms to multiple sclerosis.

Professor Marcus Singer, Henry Willson Payne professor of anatomy and director of the department, received $20,363 for his research into the composition of myelin.

Richard T. Johnson, M. D., assistant professor of neurology, was given $15,801 to investigate the problem of latent viruses and their possible relationship to multiple sclerosis.



Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

nduronyl: Its deserpidine component dds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

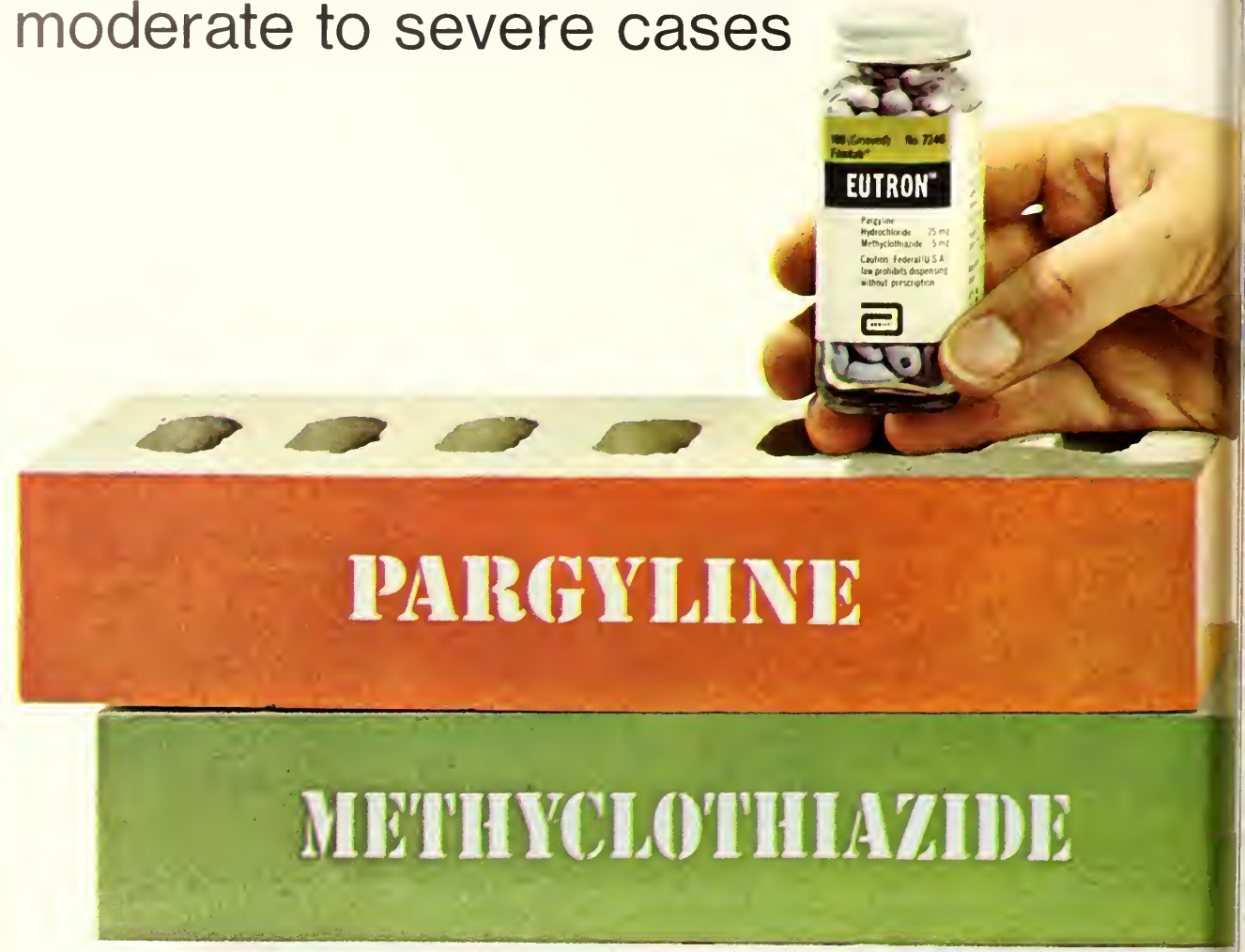
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NDURONYL®
YCLOTHIAZIDE 5 mg. with
PIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801024

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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BROWN—Philip A. Pealzgraf, President, 1830 Ohio Pike, Route 1, Batavia 45103; Robert S. Benintendi, Secretary, 117 West Cherry Street, Georgetown 45121. Meetings monthly.

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525 North Fourth Street

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241 Hudson

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Box (insert number), c/o The Ohio State Medical Journal.
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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27 SEP 1968

The OHIO STATE MEDICAL Journal

Published By The Ohio State Medical Association

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AE 64 ★ NUMBER 9



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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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Journal

VOL. 64 SEPTEMBER, 1968 No. 9

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Address All Correspondence:
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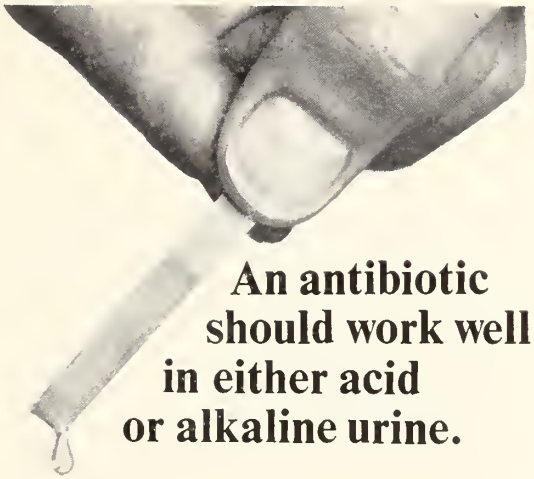
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Downward Trend in Disability Rate Shown by Study

The incidence of disability lasting eight or more days reached a new low in 1967 among field and home office personnel covered by a large nationally prominent company's group insurance program. Statisticians report that new cases of disability occurred at the rate of 118 per 1,000 personnel last year, or more than seven per cent under the previous low of 127 in 1966. Over the preceding eight-year period, the disability rate ranged from 133 to 158 per 1,000.

This downward trend in the disability rate is in general agreement with estimates of the incidence of disability in the United States population. For the year ended June 30, 1967, new cases of disability due to acute conditions were estimated to be approximately 10 per cent below the rate for the preceding year.

Both men and women in the study group shared in the 1967 decrease. Among males, rate of new cases of disability declined from 98 per 1,000 personnel in 1966 to 94 last year. Among females, the decrease was greater—from 176 to 161 per 1,000, or about nine percent. Employees at all ages, except men under age 25, recorded a lower 1967 incidence.

The major factor responsible for the lower morbidity in 1967 was a drop in disabilities due to respiratory diseases. The incidence rate from this cause declined from 31 per 1,000 to 26. Other major causes which registered a lower frequency in 1967 were diseases of the digestive system and accidental injuries.

AMA Congress on Medical Ethics Is Scheduled in Chicago

The Judicial Council of the American Medical Association has announced that its "Second National Congress on Medical Ethics" will be held in Chicago at the Drake Hotel on October 5-6.

This year's program will be a practical consideration and application of ethical principles in everyday practice. It will run the gamut of questions from relationships with ancillary personnel to the ethics of transplanting hearts and lungs. Distinguished speakers from all over the country have agreed to participate in our program.

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Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

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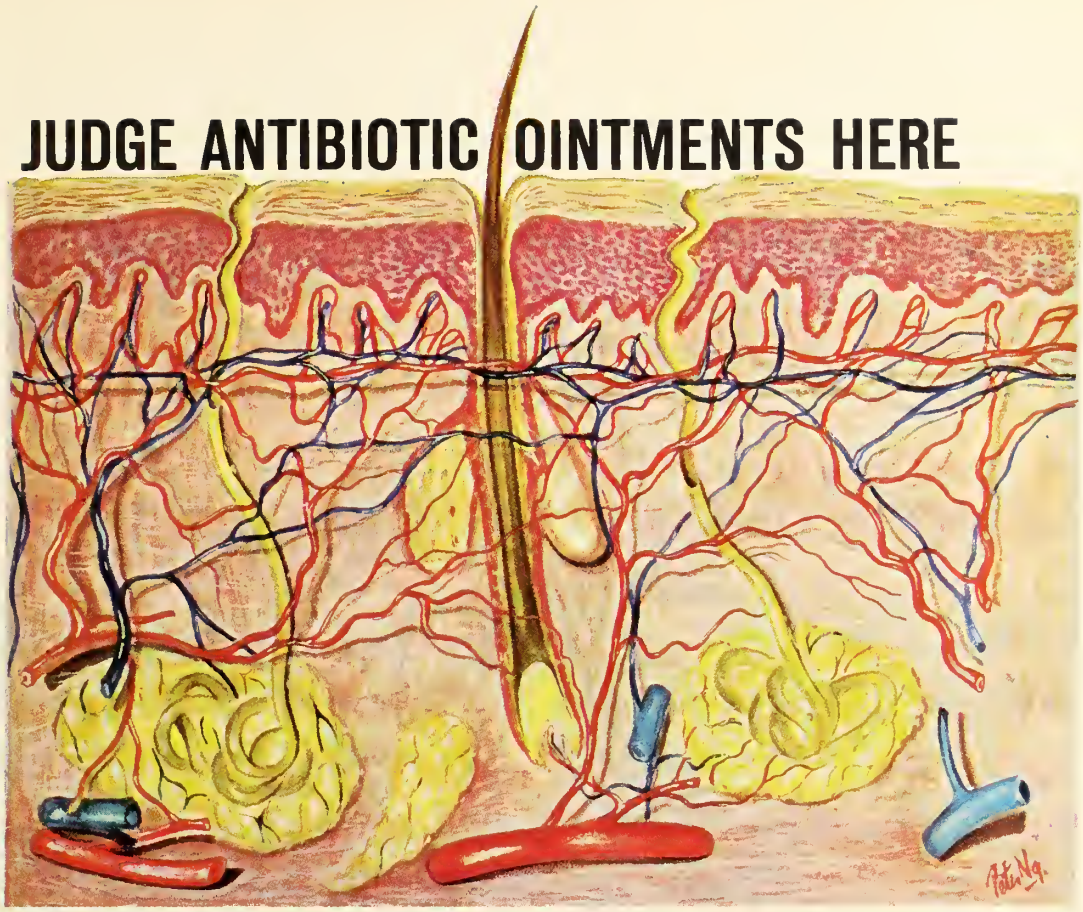
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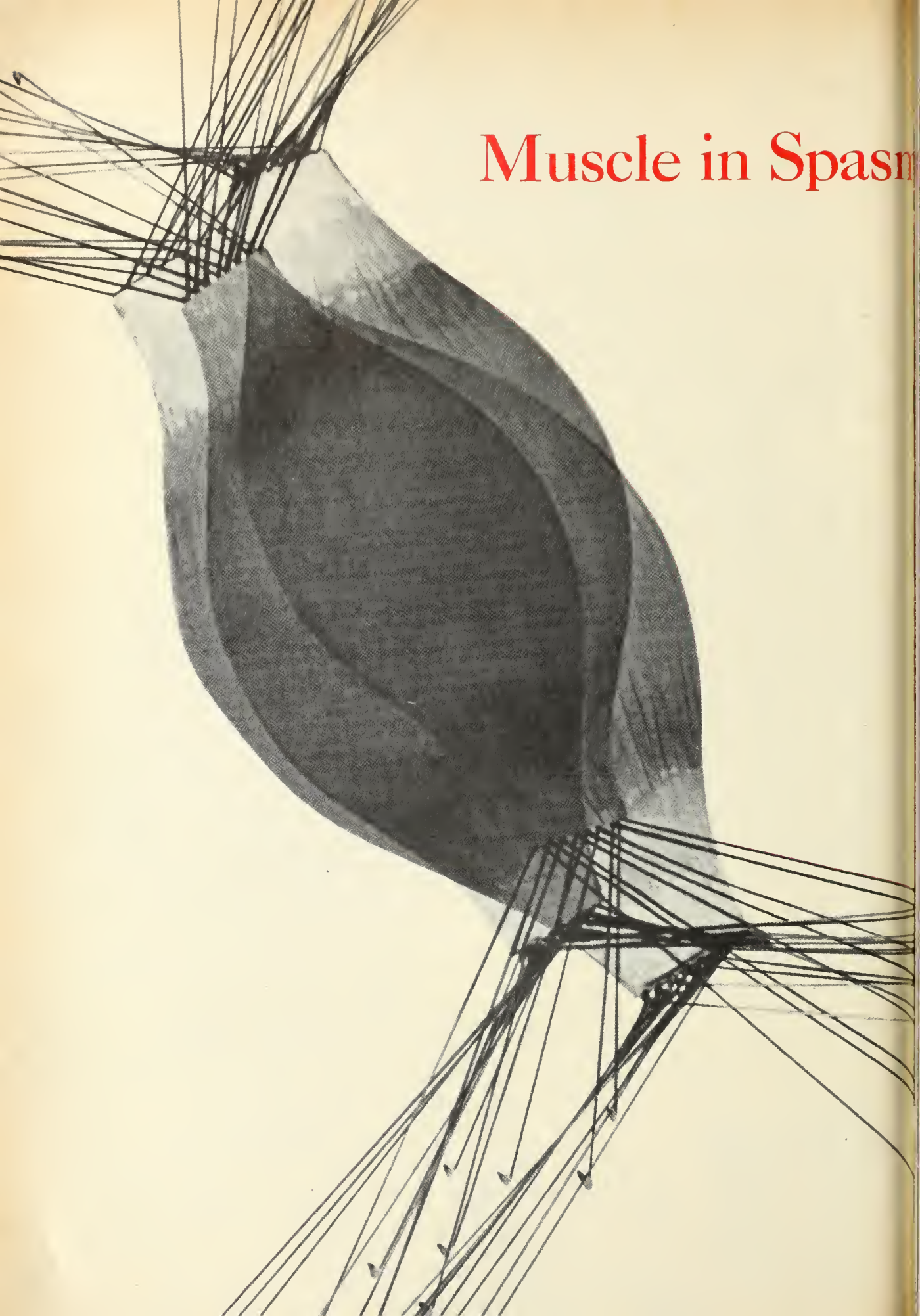
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice; skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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If it doesn't work in a week, forget

Ohio Burial Ground Shows Indians Not the Healthiest People

Following are excerpts from a news release furnished by the University Medical Center, Cleveland.

Medical and dental scientists of the University Medical Center in Cleveland are investigating the health of a village population which until last summer had been buried for a thousand years.

Skeletons of these early American Indians, ancestors of the Hurons or the Iroquois, were discovered on a farm near Port Clinton. The excavation of the site, covering four to five acres and believed to contain well over a thousand skeletons, was started a year ago. Apparently it was a village burial ground used for only three generations — from perhaps 825 to 900 A. D.

Some striking facts about the population can already be stated: Contrary to the common assumption that primitive peoples living close to nature were healthier and heartier than civilized man, these villagers were slight in stature (5′2″ to 5′4″) and lived comparatively short lives (40 was extreme old age) burdened with disease — in particular, severe arthritis and very bad teeth.

Such observations come from examinations of the first 250 skeletons by Dr. David B. Scott, professor of physical biology, School of Dentistry; and Drs. Kingsbury G. Heiple, associate professor of orthopedic surgery, and Benjamin Kaufman, associate professor of radiology, School of Medicine, all of Case Western Reserve University, who are conducting the dental-medical phase of this research project. Dr. Olaf H. Prufer, formerly of Case Western Reserve and now professor of anthropology at the University of Massachusetts, discovered the site and directed the dig and the cultural anthropological study with help from professors and students of CWRU, Cleveland State, and Kent State universities.

The first 250 skeletons offer abundant information on this subject. According to a preliminary research proposal by Dr. Heiple, "almost every single complete skeleton recovered exhibited evidence of disease, injury or genetic anomalies."

Arthritis was so prevalent that virtually every mature skeleton (18 to 40 years old) showed some form of the disease in the lower back, hip, or wrist. There were also chronic bone infections and several bone tumors. The injuries included several healed fractures and a number of arrow points imbedded in the spine and elsewhere. In four or five skulls there was evidence of post mortem surgery (possibly of religious significance): a flap of the skull had been cut and rejoined. In addition, the scientists found numerous mutilations — chiefly by decapitation.

Tooth disease was far worse in this population than has been reported for other primitive peoples.

Civilization — soft food and too many sweets — has always been blamed for dental caries and other tooth diseases. The refuse heaps of these ancient villagers do not show evidence of carbohydrates (sugar and starch) as a major component of their diet. For some unknown reason, they ate mostly fish — although meat and other foods were available and they traded with other tribes who enjoyed a more varied fare. Whatever the explanation, their diet may have medical and dental implications, the scientists believe, which could be relevant today.

Medical Technology Course Offered At the Cleveland Clinic

The Cleveland Clinic Education Foundation and the Cleveland Society of Medical Technologists are offering a symposium on Medical Technology, Friday, September 20, in the Education Building of the Clinic. Details may be obtained from the Education Secretary, Cleveland Clinic Education Foundation, 2020 East 93rd Street, Cleveland 44106.



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Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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In Our Opinion

Comments on Current Economic, Social And Professional Matters

ATTORNEY GENERAL SAXBE'S RULING ON BLOOD TESTS IS SIGNIFICANT

Of extreme importance to physicians is Ohio Attorney General William B. Saxbe's opinion regarding withdrawing of blood from drunken driving suspects. (See report of Attorney General's Opinion elsewhere in this issue.)

Mr. Saxbe has wisely and clearly expressed the opinion that since the law does not obligate a physician to draw such blood, the physician may legally refuse to do so.

Mr. Saxbe has helped to clarify the confusion caused when the Ohio General Assembly failed to provide statutory protection for physicians who draw blood at the request of law officers. He states, in his opinion, "I am of the opinion that the operation of the Ohio Implied Consent Law as it applies to the withdrawal of blood depends upon the voluntary cooperation of the medical profession."

Mr. Saxbe's opinion will help significantly in those areas where physicians are being pressured to perform such services despite the clear failure of the Ohio Implied Consent Law to provide the necessary legal protection required in such cases.

OHIO MEDICAL EDUCATORS MIGHT FOLLOW THIS LEAD

It would be excellent for Ohio's medical school deans and other educators to consider adopting the practice of the dean of the University of Washington School of Medicine.

Dean John R. Hogness spent a two-week "preceptorship" with four general practitioners in a rural Washington State community of 4,000 residents.

He came away with a tremendously improved understanding of the role of the family physician in medicine today, plus respect and appreciation for that role. Curriculum changes at the medical school he heads are expected to reflect his experiences.

To claim that there is no two-way communications gap between nonmetropolitan physicians and medical school faculties is, in the opinion of at least one observer, "to put one's head in the sand."

The Ohio State Medical Association offers two-week preceptorships for students who have completed three years in medical school. Perhaps it would be more meaningful, more productive, and more mutually beneficial if an adaptation of this program could be aimed at medical school teachers as well as students.

One thing for certain: It could be a mutual teaching experience for both preceptor and preceptee.

Any takers?

ONE VOTE DOES COUNT; BUT ONLY IF YOU CAST IT

If you are one of those citizens who must be convinced that one vote does count, take a note from Ohio's Secretary of State, Ted W. Brown. In his advice and instructions to precinct officials, Secretary of State Brown introduces his guide as follows:

"One Vote Does Count!

"The importance of accuracy in the tabulation of votes is emphasized by the fact that, time and again, election of candidates or the success or defeat of some question or issue has hinged upon a **single vote.** Just as we have stressed to each voter that his vote may be the deciding one, it is equally important that those who serve as precinct officials realize that they are the guardians of that vote and are charged with the responsibility of seeing that it is properly and accurately counted. The preservation of one of our most precious heritages — that of voting — rests with those who administer our election system!"

Excellent advice from a public official who knows statesmanship and politics inside and out! Ask any elected official and he will tell you that national, state, and local elections are won and lost on individual votes — not on some mystical "mass election."

Elsewhere in this issue of *The Journal* is an article entitled "Are You Eligible to Vote?" Details are given as to who is eligible and how others may qualify themselves to exercise their franchises.

In the coming "watershed" election each physician would do well to determine that his vote will count; that his relatives' votes will count; that his friends' votes will count.

Need any further reason? Take the admonition of another statesman and politician: . . . "that this Na-

tion, under God, shall have a new birth of freedom — and that government of the people, by the people, and for the people, shall not perish from the earth."

SERIOUS THOUGHT NEEDED ON SITUATIONS FACING PROFESSION

"The medical profession is not without resources or talent. But those resources and talents are not presently deployed in the manner they should be in order to face confidently the complicated situations of the day, and to influence effectively the public attitudes and public opinion without which the profession cannot succeed in its efforts to protect its patients and itself.

"Indeed, medicine never had it so good; nor so bad. If too many of us take the good for granted, however, without working to support it and overcome the bad, our apathy will lead to controls on the profession which the public believes are necessary because the profession itself did not solve the problems that need to be solved.

"It is absolutely vital that every physician become clearly aware of the situation that faces his profession and its services; and aware that if he wants to strengthen and preserve what he now has . . . and improve conditions for the future . . . it is his obligation to get the job done.

"Nobody can do it for him. 'The time is out of joint.' But the physician—in part—'was born to set it right.' "

The foregoing excerpts are from one of the "Vital Speeches of the Day," given by Dr. F. J. L. Blasingame, Executive Vice-President of the AMA, under the title, "Problems of a Free Health Market —The Betterment of the Profession."

In our opinion, an earlier statement from Bing Blasingame's talk sums up the situation: "Certainly the time does appear to be out of joint, and members of the medical profession must accept the responsibility of providing leadership in setting it right."

Ohio Area ACP Regional Meeting Scheduled in Pittsburgh

The American College of Physicians is sponsoring 33 regional scientific meetings during the coming academic year — September, 1968 to April, 1969 — for internists throughout the United States and Canada.

Lists of the meetings and other information may be obtained from the American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

The regional meeting for Ohio, Western Pennsylvania, and West Virginia will be held at the University of Pittsburgh, Pittsburgh, Pa., November 22-23. Information for this program may be obtained from William M. Cooper, M. D., 1134 Chapel Road, Pittsburgh.



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One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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he can't eat bulk foods

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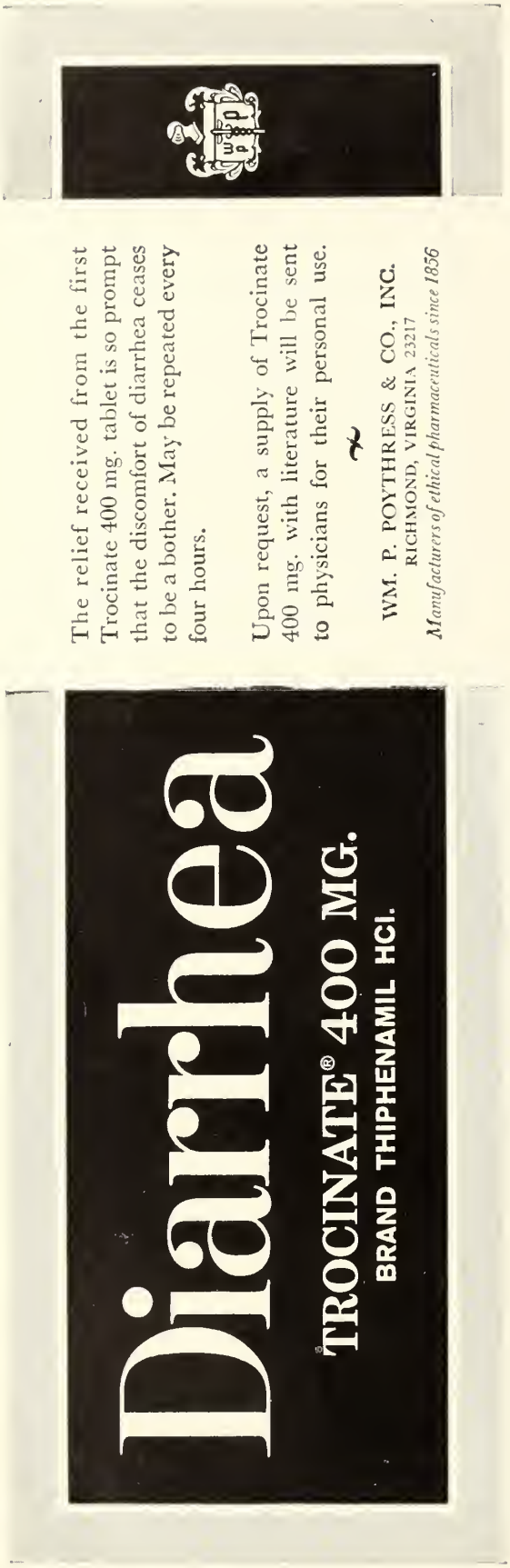
Provides gentle overnight relief of constipation.
Encourages regularity.

COMPOSITION AND DOSAGE: MODANE Tablets (Yellow)...each contains 75 mg. danthron, 25 mg. d-calcium pantothenate...1 tablet with the evening meal, or as required by patient.

MODANE MILD Tablets (Pink)...each contains 37.5 mg. danthron, 12.5 mg. d-calcium pantothenate (half strength for hypersensitive, pregnant, pediatric, and diet-restricted patients)...1 tablet with the evening meal, or as required by patient.

MODANE Liquid...each teaspoonful (5 cc) contains 37.5 mg. danthron, 12.5 mg. d-calcium pantothenate...Adults—1 to 2 teaspoonfuls with the evening meal. Children 12 years—¾ to 1½ tsp.; 6 years—½ to 1 tsp.; 3 years—⅓ to ⅔ tsp.; Infants 1 year—¼ tsp.; 6 months—⅕ tsp. (20 drops)—or as required by patient.

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Physician Population Increases Annual AMA Report Shows

An estimated 7,966 June (1968) medical school graduates raised the total U. S. physician population to 315,868, according to an American Medical Association report. The number of 1968 graduates is an increase of 217 over the last year and 879 more than in 1960.

During the 1967-68 school year five new medical schools opened their doors. They are: University of Arizona School of Medicine, Brown University Program in Medical Science, University of Hawaii School of Biomedical Sciences, Michigan State University College of Human Medicine, Pennsylvania State University Milton S. Hershey Medical School.

This brings to 94 the total number of schools now in operation — an increase of 17 since World War II. By 1971, an additional 10 schools will be added, making a total of 104. Twenty of 30 other medical schools have been proposed.

Workmen's Compensation Processing Will Be on Two-Week Basis

The accumulation time for processing of medical bills by the Bureau of Workmen's Compensation has been reduced to a two week period, according to a memorandum from Jay C. Flowers, administrator.

Before the change in July, bills for a given hospital, doctor, or drug store were on a four week cutoff basis. Notification of the new procedure has been sent to many physicians in envelopes with Bureau checks.

Pennsylvania Medical Society Offers Scientific Seminars

The Pennsylvania Medical Society will present this fall its first solely scientific session. Seminars for physicians will be presented on Sunday, October 27, and Monday, October 28, with the general theme, "Electrolyte Metabolism and Renal Diseases." Place is the Chatham Center in Pittsburgh.

Evening program on Sunday will be a symposium on group practice, and on Monday evening a program on the status of organ transplantation.

A seminar for nurses and allied professions will be given on Monday on the subject of renal diseases.

Specialty societies will hold programs on Tuesday, October 29.

Details may be obtained from the Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pa. 17043.



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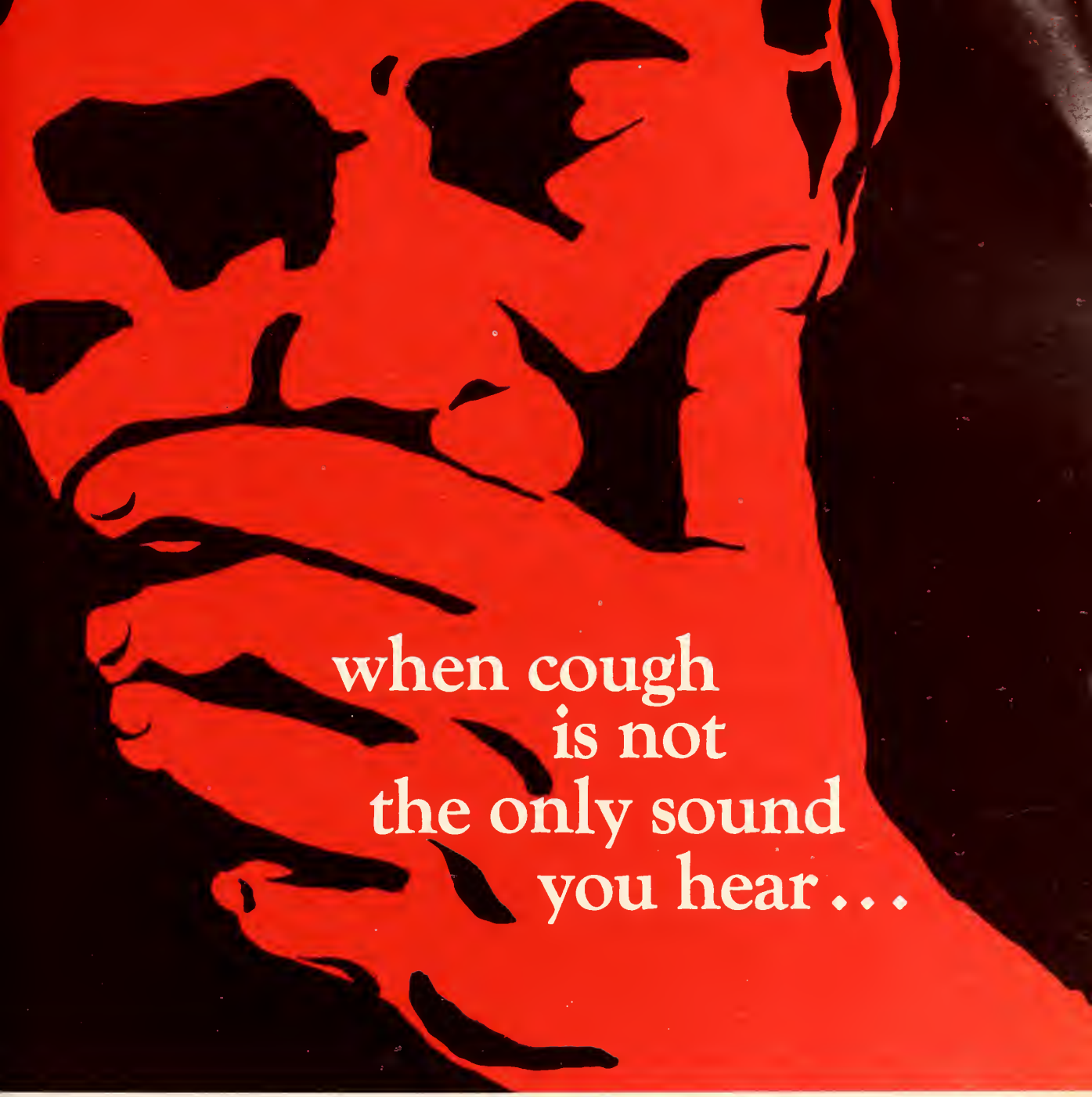
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The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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a
macrolide
antibiotic for the
frequently seen
respiratory infection
in the office
and
for a problem pathogen*
in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81.
(8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

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In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticaria type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J.

Ohio Chapter, ACS, Annual Meeting Youngstown, September 20-21

The Ohio Chapter of the American College of Surgeons will hold its 13th annual meeting and scientific program at the Ohio Hotel, Youngstown on Friday and Saturday, September 20 and 21. The program begins at 8:45 A.M. on Friday and the breakfast meeting on Saturday begins at 7:30 A.M. The program has been announced as follows:

Saturday Morning, Sept. 20

Presiding—Stephen Ondash, M. D.

Welcome Address—Richard W. Zollinger, president, Ohio Chapter, ACS.

Postoperative Management of Fluid and Electrolyte Derangements—Moderator, John H. Davis, M. D.; Panelists: James L. Berk, M. D., Leonard I. Goldman, M. D., and Bruce G. MacMillan, M. D.,

Metabolic Problems of the Surgical Patient—Moderator, Thomas R. Kelly, M. D.; Panelists: Thaddeus S. Danowski, M. D., David M. Hume, M. D., and Robert A. Macbeth, M. D.,

Ohio Cancer Coordinating Committee's Tumor Registry Program—P. John Robechek, M. D.

Noon Luncheon—Luncheon Speaker: Angus D. McLochlin, M. D., "Surgery in Africa."

Friday Afternoon

Presiding—Richard W. Zollinger, M. D.

Resident Essay Contest—Mary M. Martin, M. D., Chairman. Ohio Oration, Charles A. Hufnagel, M. D., "Current Status of Valvular Replacement."

Pre- and Postoperative Cardiopulmonary Problems—Moderator, John J. Turner, M. D.; Panelists: Laurence K. Groves, M. D., Charles A. Hufnagel, M. D., John L. Pool, M. D., and Angelo Riberi, M. D.

Business meeting.

Friday Evening

Social Hour and Dinner—Dinner Speaker: Red Barber, Sports Columnist, "What Makes a Champ?"

Saturday Morning, Sept. 21

Presiding—Thomas W. Morgan, M. D.

Breakfast Meeting — **The Relationship Between Surgeon, Administrator, and Governing Board of the Hospital"** — Moderator, James H. Spencer, M. D.; Panelists: John J. Cranley, M. D., Charles E. Holzer, M. D., Donald R. Newkirk, and Frank L. Shively, Jr., M. D.

Management of Patient with Multiple Injuries—Moderator, Wesley Furste, M. D.; Panelists: Robert J. Baker, M. D., Leon L. Bernstein, M. D., Irving M. Bush, M. D., Nicholas J. Giannestras, M. D., and H. William Porterfield, M. D.

Ohio Gall Bladder Surgery — Drew J. Arnold, M. D.

Management of Acute Renal Failure—Moderator, Donald G. Vidt, M. D.; Panelists: Irving M. Bush, M. D., Richard Ireton, M. D., and Victor Vertes, M. D.

Obstetrical and Gynecological Scientific Session Friday Afternoon, September 20

Place: Youngstown, Voyager Inn; session begins at 2:00 p.m.

Presiding—Richard T. F. Schmidt, M. D.

Genetic Abnormalities in Reproduction—Moderator, Raymond S. Lupse, M. D.; Panelists: Cecil B. Jacobson, M. D., and Morton A. Stenchever, M. D.

Surgical Management of Congenital Vaginal Defects — Intersexuality and Its Management—Moderator, Donald C. Snyder, M. D.; Panelists: Theodore A. Beromid, M. D., and Roger B. Scott, M. D.

The Management of the Rape Victim—Moderator, Simon W. Chiasson, M. D.; Panelists: Lester Adelson, M. D., and George Andros, M. D.



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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
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The Historian's Notebook

From the Dresden Hygiene Museum to the Cleveland Health Museum

BRUNO GEBHARD, M. D., Cleveland, Ohio*

PART I

"EARNESTLY invite you come America — our expense — six months or more — help arrange display Health Exposition Rockefeller Center — also develop plans future exhibitions." This wire was an invitation of the Oberlaender Trust of the Carl Schurz Memorial Foundation (Philadelphia) for Mrs. Gebhard and myself to come to New York in the fall of 1937.

I had enjoyed contacts with American health educators since the days of the Second International Hygiene Exposition in Dresden 1930-1931. In 1934 I was in charge of an extensive exhibition "Eugenics in New Germany" for the Annual Meeting of the American Public Health Association in Pasadena. This exhibit was created in the workshops of the German Hygiene Museum and the then timely subject was suggested by an American group under the leadership of the late W. W. Peter, M. D., who had spent some time with me in Germany as an Oberlaender fellow. Another Oberlaender fellow at that time was Richard A. Bolt, M. D., for many years the ardent director of the Cleveland Child Health Association.

Via the New York World's Fair to Cleveland

I had to return to Germany after the Pasadena meeting but I had become well acquainted with the members of the Committee on "An American Museum of Health and Hygiene," among them Homer N. Calver, Prof. Haven Emerson (1874-1956) of Columbia University, Victor Heiser ("An American Doctor's Odyssey"), and Louis I. Dublin of the Metropolitan Life Insurance Company. The first two named came to Dresden in 1936 after the Olympic Games to select 100 exhibits including the famous "Transparent Man" as core for a planned "National Health Museum" in New York.

The six-month trial run at the then Museum of Science and Industry at Radio City proved to be so successful that I was asked to stay on. I became a "Technical Consultant" for the Hall of Medicine and Public Health at the New York World's Fair (1939-40). Up to that time I was not aware that already in 1936 Lester Taylor, M. D., (Cleveland Academy of Medicine), Howard Whipple Green (Cleveland Health Council), and James A. Doull, M. D., Professor of Preventive Medicine, Western Reserve University, had incorporated a "Cleveland Museum of Health and Hygiene." In the fall of 1939 I was asked to take over the directorship of the first museum of this type in the U. S. A.

Growing Up in a Hospital (1901-1921)

Up to my 21st birthday I lived in a hospital. My father had started out as a *Hauswart* (custodian) of the *Medizinische und Chirurgische Klinik* of the University of Rostock (Mecklenburg) in 1897. He had attended for only six years a one room country school on the estate of the Duke of Bluecher where the Gebhard family had been tenant farmers since 1720. By self-study and by attending adult evening school my father worked himself into an administrative job as an admissions officer. As we had living quarters in the clinic building, sick people and their families, day- and night-time emergency cases, studets and nurses, physicians and surgeons and, on top of them all, the *Herr Professor* or the *Herr Geheimrat* were my daily surroundings.

As a sideline my father ran a well-frequented *Bierstube* (beer cellar) at the clinic for the medical students and was jokingly referred to as "Director of the Wurst (sausage) Clinic." During his more than 40 years with the clinic my father — by sheer personality — not only became the father confessor of many generations of students but also the confidant of the ever-changing members of the Medical Faculty. This way I learned a great deal about the good and bad sides of medicine, its academic world, and its daily practice during the first two decades of my life.

Early Childhood and School Years

I grew up an only child, since my mother died of typhoid fever when I was just seven months old. I was reared by my maternal grandmother and next to

*Dr. Gebhard is Director Emeritus, the Cleveland Health Museum.

This paper was read at the 1968 Annual Meeting of the Ohio Academy of Medical History, March 30, 1968 at Granville, Ohio.



Is it depression?
He says "It's my stomach..."

...but his other symptoms:
functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt
strongly suggest an underlying depression.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

her by "Aunt Thea," the head nurse of the surgical clinic, who was also my godmother. Aunt Thea was my intellectual mentor in my preschool days. She opened my eyes to the world beyond the hospital and later on helped me to satisfy my incessant desire for reading. I loved going to school without becoming a teacher's pet.

The beginning of World War I was a shattering experience. I was one of the youngest male nurses in the hospital. These were still the days of the horse-drawn ambulances and I remember the first wounded soldiers coming by Red Cross Train from the Russian Front. We then had to carry them on stretchers from the railway station to the hospital.

In the spring of 1916 I graduated from our local *Realschule* which qualified me for only one year of military service instead of the regular two years training. But I was anxious to go to a university — I wanted to become a doctor. Since the *Realschule* only taught French and English, I had to take private lessons in Latin for six months to qualify for the *Gymnasium.* (By the way, Latin is still a required subject for medical students in both West and East Germany.) In the fall of 1919 I passed the *Abiturium* at our *Realgymnasium* together with five fellow students.

Medical School

I entered the Medical School of the University of Rostock, founded 1419. Most of my fellow students were war veterans, they were older, more mature, and more cynical. Remodeled army uniforms were the dress of the day — called "Kaiser Wilhelm Memorial Outfits." On account of the war, the faculty was overaged. Fortunately in our second year young and brilliant anatomists Curt Elze and R. E. Wegener became our teachers. Prof. Hans Winterstein not only taught us physiology, but scientific thinking. Thirty years later, having been a refugee from Nazi Germany in Turkey, he came to Cleveland to give the Bloomfield Memorial Lecture at Western Reserve University (October 7, 1955) and we exchanged memories of our days at our old Alma Mater. Lectures in zoology by Professor von Frisch were especially interesting when he talked about his own experiments on the behavior of bees.

Studium Generale

Small university towns have the advantage that their medical schools usually are in close contact with their other faculties. I could afford to skip classes in botany, chemistry, and physics since the respective university professors had been our teachers in the same subjects at the *Realgymnasium.*

I took full advantage of the *akademische Lernfreiheit.* I took courses in philosophy, theology, and history of art and spent a lot of time at the library reading up on economy, sociology, and political science.

I was asked to join two of the students' corporations, *Obotritia* and *Wingolf,* but declined and joined the Christian Students Association. In this way I met John Mott, the internationally known evangelist and his son, Frederick Mott, M. D., who is well known as a pioneer of medical prepayment plans in Canada and here. I was fortunate that my first contact with foreigners happened to be the American Friends (Quakers) working in the Hoover program of feeding children all over Europe.

I enjoyed my preclinical years, but a dilemma came creeping up. I had no interest in the business end of the medical practice, but hoped to pursue an academic career, preferably in pediatrics. However, you had to be in a financially independent position for that — which I wasn't.

Political Unrest

My additional years in medical school coincided with the aftermath of a lost war, the Versailles Treaty, an increasing inflation, the struggling days of the Weimar Republic. We students were torn between Nationalism and Socialism. In March 1920, the "Kapp Putch" — a monarchistic uprising — pitted regiments of students against armed trade union members. Prof. Ernst Schwalbe, well known as pathologist and medical historian, was killed in these fights. His son had been a classmate of mine, so I was quite shaken. But more important, with a group of my fellow students I had publicly stated my sympathy with the trade unions. As the majority of my fellow students joined the ranks of the secret "Schwarze Reichswehr" (Black Army), a change of university, an accepted custom with students in Germany, seemed to be in order.

A Summer in Munich

I spent the summer of 1921 in Munich. There are very few required courses during the preclinical semesters in Germany and even in the required courses no attendance checks are made. I arranged my working week in such a way that the first three days were devoted to anatomical and physiological lectures. (I even found time to attend E. Kraepelin's lectures in psychiatry.) The other three days I walked from the *Mediziner Viertel* to the University. I read philosophy and sociology and managed someway to be admitted to a "Seminar on the Drama and the Theatre" by Professor Kutscher which opened my eyes to the art aspects of the "Athens on the Isar" and to the female members of that group!

Munich in the early twenties was very much alive with good theater, music, and literature — Thomas Mann lived there. But Munich in those days also saw the beginnings of the Nazi movement. Eight-feet-high red placards at many street corners invited everybody to political protest rallies. These placards stated in large letters "Jews are not allowed to attend." But the majority of students did not take these things seriously. During the summer days one preferred hiking trips in the Alps anyway.

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Interest in Public Health

After returning to the university of my home town in the fall of 1921, I enrolled in Prof. Hans Reiter's "Seminar in Soziale Hygiene" (Public Health). Dr. Reiter is best known in the U. S. A. as the discoverer of Reiter's disease (1917). This seminar was an innovation in the medical curriculum as its members were not only students of medicine but also of law, economics, and sociology. Among the most interesting features of the seminar were 10- to 14-day long study trips during vacation times. We visited industrial plants, coal mines, public housing projects, welfare organizations, and health centers in the Ruhr Valley, Saxony, Berlin, and Hamburg.

Here we encountered firsthand the socioeconomic problems of industry and the so-called *arbeitende Klasse* (the working class). But it was not all work and study on these field trips. Professor Reiter arranged for us to meet leading personalities of those days such as the Lord Mayor of Essen, Dr. Hans Luther, who later became German Ambassador to Washington. On one of these trips we visited the workshops of the German Hygiene Museum in Dresden and an exhibition on "Social Welfare and Housing." I was deeply interested in these modern technics but did not dream then that my own life for nearly 40 years would be spent in this field. I still had to pass the *Physicum,* which I did in the spring of 1922, and I still had five semesters of clinical studies before me.

A Year in Berlin

Great medical teachers like E. F. Sauerbruch, Ernst Bumm, and A. Czerny drew many medical students to Berlin in the early twenties. My main attraction was Alfred Grotjahn who held the first chair of Social Medicine established in 1911. His book *Soziale Pathologie* became my bible. Grotjahn's Monday evening seminars (8 to 10 P. M.) became the meeting place for social reformers, progressive medical politicians, proponents of group practices.

Like Rudolph Virchow, Grotjahn was active in politics, he too was a member of the German Reichstag. (He was a Social Democrat.) At the 20th International Congress for the History of Medicine (Berlin 1966), I gave a detailed analysis of Grotjahn's influence not only in Germany but also in the English speaking countries, as many of his students, for political or racial reasons, emigrated to England or the U. S. A. I was one of them.[1]

Henry E. Sigerist gives credit to A. Grotjahn for his own interest in social medicine — he wrote in his diary March 25, 1940: "I always intended to develop a section on medical sociology at the Institute (for the History of Medicine at Johns Hopkins) to form a group of students similar to those in the Seminar of Grotjahn in Berlin.[2]

With Alfred Grotjahn I had found my scientific anchor place, both in medicine and public health and I hoped to write my doctoral thesis on a subject selected by him. But in the wake of the Ruhr invasion and the passive resistance of the trade unions, the value of the German Mark rapidly went down. My tuition fee in the winter of 1922-1923 amounted to 820 Marks and in the summer semester of 1923 it went up to 16,000 Marks, so I had to return home.

I graduated cum laude in December 1924 and, after a year of internship, received the degree of *Doktor der Medizin* in December 1925.

My doctoral thesis dealt with the health status of the school beginners of 1920 to 1923 who had been born and grew up in the hungry years of World War I. During my year in Berlin I had lived and worked in a social settlement, had given lectures in adult education classes and dreamt of combining pediatrics with education. But I was not sure how to go about it. The financial calamity was still with us. Had it not been for the help of American friends, my doctoral dissertation would never have appeared in print.

The German Hygiene Museum

After a year of residency in pathology in Leipzig and another one at the Children's Hospital in Dortmund (Prof. Dr. Stephen Engel), in the spring of 1927, I became Research Assistant and later on *Kustos* (curator) of the German Hygiene Museum. This position also made possible my marriage to Gerta Adolph on April 8, 1927. For three years a large staff of scientists, designers, and technicians worked on the exhibits for the first permanent building of the Hygiene Museum and for an International Exhibit. Both opened in May 1930.

The Museum, rebuilt after its total destruction during the air raid of February 13, 1945, is a monumental structure 300 by 480 feet with a height of 57 feet. There are 54,000 square feet available for exhibit purposes alone. The same amount of space is allocated for workshops and administration.

My field was child health, and what we now call in this country family life education, was then titled "The Woman as Wife and Mother."[3] We had a trial run of this material in Vienna in 1928 which brought the unusual honor (at least for a 27-year-old young man) of a decoration by the Austrian Government. As I was one of the few English speaking staff members, it was up to me to take care of foreign V.I.P.'s, including Rabindranath Tagore, "Papa" Welch from Johns Hopkins, Stampar from Yugoslavia, and many members of the Hygiene Section of the then League of Nations. Some lifetime friendships developed that way as with Mrs. Ursula Grant Duff, the daughter of Lord Avebury (Sir John Lubbock) who had grown up next door to Charles Darwin (1809 to 1892) in Downe which we later visited under the guidance of Sir Arthur Keith.

(To be concluded in October Issue)

Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.

MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.

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See Brief Summary on final page of advertisement

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Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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Pneumocystis Carinii Infestation

Four Cases with Associated Lymphoma

WALLACE J. MULLIGAN, M.D., FRANKLIN D. KRAUSE, M.D., WILLIAM MORNINGSTAR, M.D., and GERALD L. BAUM, M.D.

PNEUMOCYSTIS CARINII pneumonia has been reported with increasing frequency in the American literature over the past ten years.[1-4] Most cases have been seen in infants,[4,5] and in children with dysglobulinemias.[6] When seen in adults the disease is usually associated with lymphoproliferative disorders,[4,7,8] or immunosuppressive therapy.[2,9] In a few adults, *Pneumocystis carinii* pneumonia has been the only disease.[10-13]

Usually the definitive diagnosis of *pneumocystis* infestation is made postmortem and can only be suspected during life.[14,15] However, open lung biopsy,[8,16,17] examination of material from the hypopharynx,[18] thoracentesis,[19] and percutaneous lung aspiration[20,21] have all been used on one or several occasions to establish *pneumocystis* infestation as the cause of unexplained pulmonary infiltrates prior to death. Although percutaneous needle biopsy of the lung has been suggested as a diagnostic procedure in this condition,[5,22] there is no report in the literature of the diagnosis made by closed chest biopsy. It is our purpose to present three cases of *Pneumocystis carinii* pneumonia occurring in conjunction with Hodgkin's disease and one which occurred with chronic lymphocytic leukemia and which was diagnosed antemortem using the technic of percutaneous needle lung biopsy recently reported by Krumholz et al.[23]

The following four cases represent over 20 years' experience in the Pathology Department of the Cleveland Veterans Administration Hospital during which time more than 6800 autopsies were performed.

The Authors

● Dr. Mulligan, Shaker Heights, is Research Fellow, Cleveland Veterans Administration Hospital.

● Dr. Krause, Cleveland, is Research Fellow, Pulmonary Diseases, Cleveland Veterans Administration Hospital.

● Dr. Morningstar, Shaker Heights, is Assistant Chief of Pathology, Laboratory Service, Cleveland Veterans Administration Hospital; Assistant Professor of Pathology, Case Western Reserve University School of Medicine.

● Dr. Baum, Cleveland, is Chief, Pulmonary Section B, Cleveland Veterans Administration Hospital; Associate Professor of Medicine, Case Western Reserve University School of Medicine.

Case 1

A 29-year-old white male was admitted to the Cleveland Veterans Administration Hospital in Octo-

From the Pulmonary Section, Medical Service, and the Laboratory Service, Veterans Administration Hospital, Cleveland, Ohio, and from the Departments of Medicine and Pathology, Case Western Reserve University School of Medicine, Cleveland, Ohio.

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ber 1953 because of cervical adenopathy diagnosed Hodgkin's granuloma and treated with local irradiation. In September 1955, he developed weight loss, malaise, and cough. He responded briefly to treatment with nitrogen mustard and transfusions, but his condition deteriorated, prompting use of steroids and more nitrogen mustard. In February 1956, a cavity appeared in the right upper lobe and an infiltrate in the right lower. Sputum culture revealed hemolytic *Staphylococcus aureus*. He died ten days later.

Postmortem examination revealed the granulomatous form of Hodgkin's disease involving the spleen (820 Gm.), vertebral bone marrow, and many deep lymph node groups. Both the sarcomatous and granulomatous varieties were found in the liver (3700 Gm.), gallbladder, and cystic bile duct. Cytomegalic inclusion bodies were found in the lungs and mucosal glands of the esophagus. Microscopically, the alveoli contained a granular proteinaceous eosinophilic material with edema, hyperemia, and round cell infiltration of the alveolar septa. Silver stains and periodic acid Schiff's reaction showed *Pneumocystis carinii*.

Case 2

A 38-year-old white male schizophenic had been institutionalized for ten years until 1954 when Hodgkin's disease was diagnosed by biopsy and was treated with local irradiation. From 1957 until 1964, he was treated intermittently with nitrogen mustard, chlorambucil, cyclophosphamide, and blood transfusions. A chest film in January 1964 showed an infiltrate in the right lower lung field. Despite treatment with chlorambucil, irradiation, and steroids, the patient deteriorated and died in September 1964.

Postmortem examination revealed widespread Hodgkin's disease with the granulomatous form in the lungs, lymph nodes, and kidneys and the sarcomatous type in the liver, spleen, bone marrow, and adrenal glands. *Pneumocystis* pneumonia was found in both lungs.

Case 3

A 41-year-old-white male was admitted to the hospital on July 18, 1966 complaining of mild back pain "pneumonia" and lymphadenopathy for three weeks prior to admission. Initial examination revealed enlarged lymph nodes and mild confusion. The hematocrit, leukocyte, and differential counts were within normal limits. Serum albumin was 2.7 Gm/100 ml. and globulin 4.0 Gm/100 ml. The chest film, normal six months previously, demonstrated diffuse bilateral pulmonary infiltrates. Cervical lymph node biopsy revealed Hodgkin's granuloma. Despite antibiotic therapy, including amphotericin, he died 18 days after admission.

Postmortem examination revealed Hodgkin's granuloma involving chiefly the deep lymph nodes and lungs with focal involvement of the vertebrae, spleen, liver, and thyroid gland. Scattered areas of the left lung and right lower lobe were firm, flat, dry, granular, and mottled yellow to grayish-white in color and revealed *Pneumocystis carinii* on special stain.

Case 4

A 64-year-old white man with chronic lymphocytic leukemia diagnosed two years before was transferred to the Cleveland Veterans Administration Hospital on September 12, 1966. Treatment consisted of cyclophosphamide, steroids, and irradiation until August 18, 1966, when a chest film (Fig. 1) revealed linear and nodular infiltrates in both lower lung fields.

Physical examination revealed a cachectic white male with scattered lymphadenopathy, minimal hepatosplenomegaly, and tachypnea. The hematocrit was



FIG. 1. *Case 4. P-A chest x-ray showing patchy bilateral infiltrate.*

39 per cent and leukocyte count 39,750 with 72 per cent lymphocytes, 15 per cent neutrophils, and 11 per cent immature forms. Chest x-ray later revealed worsening with extensive infiltrate in the lower left chest. (Fig. 2) A scalene lymph node biopsy revealed malignant lymphoma, (Hodgkin's sarcoma?). Needle biopsy of the left lower lobe on September 27, 1966 revealed *Pneumocystis carinii* pneumonia (Fig. 3). Despite treatment with 180 milligrams of pentamidine isothionate,* he died five days after the lung biopsy.

Postmortem examination revealed chronic lymphocytic leukemia involving the spleen (420 Gm), bone marrow, and lymph nodes with foci of reticulum cell sarcoma in the para-aortic and left scalene lymph nodes. Microscopic examination of the lung revealed

* Obtained from Rhodic, Inc., 600 Madison Avenue, New York, New York, 10020.

Pneumocystis carinii in eosinophilic proteinaceous intra-alveolar material (Figs. 4 and 5) similar to those demonstrated by needle biopsy.

Discussion

The interesting historical aspects of *Pneumocystis carinii* from its description by Chagas in 1909 until its identification as the etiologic agent of plasma cell pneumonitis in 1952 have been described adequately elsewhere.[5,24,25] However, the problems of taxonomy and the relevance of experimental work remain unclear.[25,26] The ability to identify the organism by histochemical technics such as the Gomori (Grocott) silver stain has convinced some workers, as cited by Hamperl,[24] that the organism is a fungus. More widespread is the opinion that *Pneumocystis* is a protozoan.[24]



FIG. 2. *Case 4. P-A chest x-ray one month after first x-ray showing marked increase in infiltrate especially on the left.*

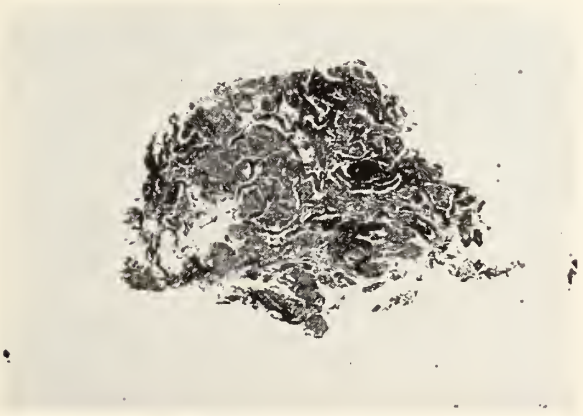


FIG. 3. *Case 4. Section of the needle lung biopsy to show intra-alveolar proteinaceous and vacuolated material and sparcity of inflammation. H & E*

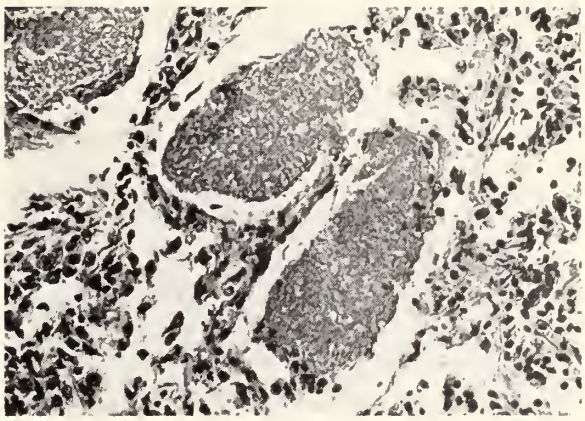


FIG. 4. *Case 4. Section of lung taken at postmortem examination to show intra-alveolar proteinaceous material and scant round cell infiltration of septa. H & E*

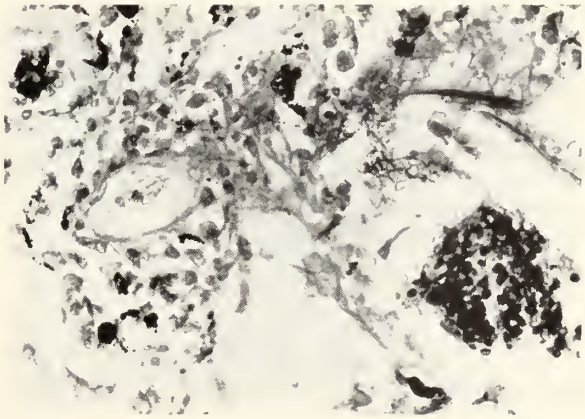


FIG. 5. *Case 4. Section of lung taken at postmortem examination to show the Pneumocystis carinii within the alveoli. Grocott silver-methenamine stain.*

The four cases presented here were associated with lymphoproliferative disease, and one of them received no antitumor therapy including steroids. The latter is an unusual event in adults. Diagnosis at autopsy was based on characteristic histologic findings and demonstration of the organism by special stains. Of greater significance was the premortem diagnosis made accurately by histologic examination of needle lung biopsy specimens.

Treatment with pentamidine or pyrimethamine should be tried since their effective use has been reported [6,9] and the disease is almost certainly uniformly fatal.

Summary

Four cases of *Pneumocystis carinii* pneumonia are reported, three occurring in association with Hodg-

kin's disease and one with chronic lymphocytic leukemia. One case was diagnosed antemortem by percutaneous lung biopsy. The existence of agents which may be effective in treatment makes early diagnosis a necessity.

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DAWSON'S ENCEPHALITIS. — One case of Dawson's encephalitis is reported in detail including clinical data, electroencephalographic findings and postmortem examination. This is the third case to be reported in the State of Tennessee, where the first two cases were originally described by Dawson in 1933 and 1934, and is the thirteenth in the United States.

The authors stress the need for a high degree of suspicion of this rare disease in pediatric cases showing progressive and diffuse deterioration of the CNS, frequently manifested clinically by transition from normality to changes in personality, behavior aberrations, intellectual regression, motor disturbances and seizures. These findings coupled with often characteristic EEG. pattern and increased C. S. F. gamma globulins can lead to correct clinical diagnosis in most cases. It is possible that if the physician is on the alert to the possibility of this disease and considers it in the differential diagnosis of pediatric cases of degenerative diseases of the CNS, seizure disorders, encephalitis and brain tumor, that more cases could be properly diagnosed in life. The only definitive diagnosis of this disease, however, is the confirmation by careful histopathologic study of the brain. — Danilo A. Duenas, M. D., and Helio Lemmi, M. D., Memphis, Tenn.: *Southern Medical Journal*, 61:226-229, March 1968.

Carcinoma of the Female Breast

Usefulness of Postoperative Radiation Therapy

R. KENNETH LOEFFLER, M. D.

IN A RECENT ARTICLE in the Ohio State Medical Journal[1] it was suggested that nasal oxygen inhalation be used to increase the effectiveness of radiation therapy following mastectomy for carcinoma of the breast. A local recurrence rate of 43 per cent following conventional therapy was cited as the reason that such adjunctive therapy is needed. The following communication is offered to demonstrate that, with adequate radiation alone, the local recurrence rate should be small.

Data

One hundred and eighty-six patients received a definitive course of radiation therapy following mastectomy for carcinoma of the breast. A "definitive course" is that given to "potentially curable" patients who have no clinical evidence of distant metastases (beyond the chest wall, axillary, and supraclavicular regions). Included are patients who have had radical mastectomies, with or without microscopically demonstrated metastases to regional lymph nodes as well as those who have had only simple mastectomies performed. This group is in no way a controlled series, consisting of patients referred by many different surgeons with widely varying backgrounds. Several "mastectomies" were indeed, only excision biopsies. Several patients who had palpable supraclavicular masses are also included. The technic of treatment is described in the next section. Figure 1 graphically gives the number of patients treated by year since 1957, with the five-year survival data included through 1962. The most recent patient included was treated more than one year ago. Five of these patients subsequently developed clinically evident recurrence of malignant disease within the treated volume.

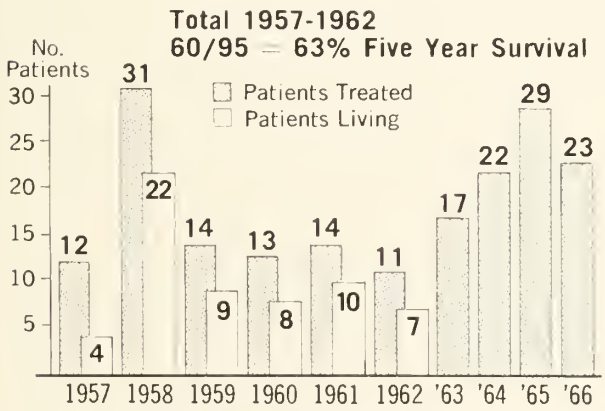


FIG. 1. *Number of patients treated by year with survival data for those treated more than five years ago.*

1. One patient treated in 1958 demonstrated skin nodules both within and outside of the treated area four years and four months after therapy.

2. One patient treated in 1960 demonstrated local skin nodules and generalized metastases eight months, and died one year and two months, after therapy.

3. One patient treated in 1963 demonstrated local skin nodules and generalized metastases two years and four months, and died two years and six months, after therapy.

4. One patient treated in 1963 demonstrated local skin nodules and generalized metastases at one year, and died one year and eleven months, after therapy.

5. One patient treated in 1963 demonstrated local skin nodules and generalized metastases at one year, and died two years and eleven months, after therapy.

Four of these patients demonstrated generalized metastases at the same time that the skin nodules appeared and probably would not have been cured even if the local disease had been permanently controlled.

Submitted February 6, 1968.

The Author

● **Dr. Loeffler, Massillon, is in the private practice of therapeutic radiology; a member of the General Staff, Massillon City Hospital, and the Courtesy Staffs of hospitals in neighboring communities.**

One of the 186 patients developed a chest wall necrosis, which has required rib resections and skin grafting. Many of the patients who had radical mastectomies have developed arm edema to varying degrees; none of those who had simple mastectomies have had this discomfort.

Eighteen patients were treated with an electron beam technic in 1961 and 1962. Five of these developed chest wall necroses requiring skin grafting. Three of these five are living, the other two having died with generalized metastatic disease. None of the 18 developed local recurrence, and ten are living and well at this time. Because of the excessive complication rate, the technic was abandoned. These 18 patients are not included among the 186 patients reported above. Male patients, female patients treated preoperatively for "inflammatory" carcinoma, and patients treated elsewhere with recurrence are also excluded.

Technic

A tumor dose of 4500 R in four weeks was delivered to most of these patients using one million volt radiation from a GE resonance generator, or 22 million volt or 25 million volt radiation from a Betatron. The postoperative chest wall and internal mammary chains were treated using directly opposing tangential portals in order to spare the underlying lung field, and the ipsilateral axilla, supraclavicular and cervical regions to the base of the skull were treated with a single anterior portal (Fig. 2 A and B). Minor angular changes in beam direction were made in order to have the chest wall area contiguous with the supraclavicular portal but without overlap, and to avoid irradiation of the spinal cord. The "roentgen" was measured with a Victoreen ionization chamber with suitable equilibrium-thickness wall, which had been standardized at the Memorial Hospital for Cancer and Allied Diseases in New York City with the Betatron "roentgen" at that Institution. Stated supraclavicular and cervical "tumor doses" are "maximum doses." Chest wall "tumor doses" are calculated midpoint minimum doses. The chest wall and any surgical incisions into the supraclavicular or upper arm regions were covered with a gelatin-glycerin block of sufficient thickness as to bring the maximum dose to the skin surface, and permit calculation of "tumor dose."

This course of therapy causes a brisk erythema to develop after the third week of therapy, which usually progresses to a moist desquamation from one to two weeks after the completion of therapy, with healing three to four weeks after therapy. Late fibrosis and telangiectasia (three to four years after therapy) have been rare.

Discussion

This report is intended to demonstrate that a high rate of local control can be achieved with adequately

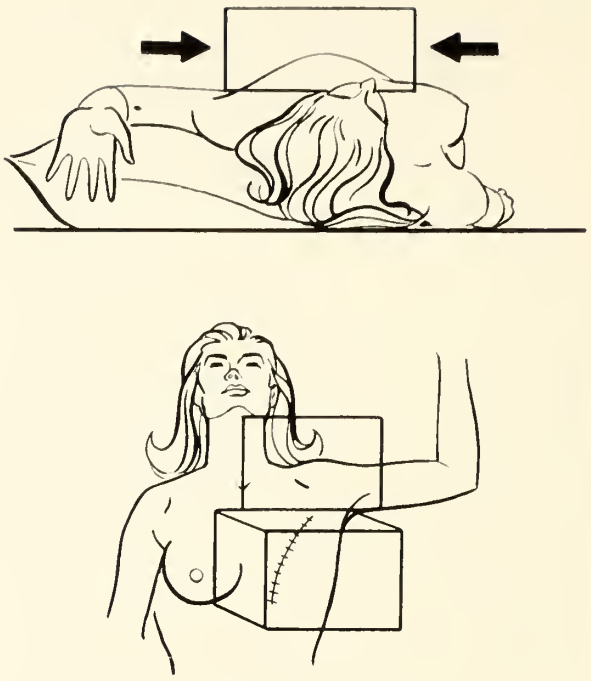


FIG. 2 *A and B. Technic of treatment.*

planned and administered radiation postoperatively for carcinoma of the breast. It is not intended to evaluate the curability of this disease or the relative merits of simple and radical operative procedures. These phases of the breast cancer problem have already been the subjects of many other publications.

However, to present these data against a general background, a brief discussion of the limitations of local cancer therapy is warranted. A "potentially curable" patient is defined as one who has no clinical evidence of distant metastases. Yet our crude methods of examination do not permit us to eliminate the possibility of microscopic foci, which could have left the primary lesion and become implanted at distant sites, perhaps before the first clinical evidence of the primary. Cure can then be effected only in those without such distant foci. This cure in turn, however, can only be achieved by permanent control of malignancy at the primary site or in areas of regional spread up to the routes of general dissemination. Evaluation of the degree of control of disease within the treated volume is a more valid criterion of the effectiveness of local therapy than is the survival rate. If local control were to be absolute, then maximum benefit from local therapy would have been achieved and the survival rate would reflect only the inherent maximum cure rate of the disease with present local techniques of treatment (i.e., either surgery or radiation).

The areas that are treated by the technic described would seem to include all possible regions where

disease could be contained before becoming generalized. The local control rate of 97 per cent (181/186) is close to absolute control. The survival rate of 63 per cent which has been attained in this group of patients compares favorably with any previously reported and probably is very close to the maximum achievable with present modalities of therapy. This is also an absolute survival rate, the 37 per cent nonsurvivors including those who died of other diseases as well as those who died of metastatic malignancy.

Conclusion

Local and regional recurrence following mastectomy for carcinoma of the breast can be prevented in a high percentage of patients given an adequate course of postoperative radiation therapy. Absolute local control would yield the maximum "cure" rate attainable with presently available local modalities of therapy, failure to cure being then due to preexisting distant microscopic metastases. The technic of therapy which has been presented in this report has given a local control rate exceeding 97 per cent with a five-year survival rate of 63 per cent.

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PSYCHIATRIC ILLNESS AFTER HYSTERECTOMY. — It was found that seven per cent of 729 women who had had a hysterectomy were referred to a psychiatrist within a mean period of four and a half years after the operation. This rate was two and one-half times higher than the incidence of psychiatric referral after cholecystectomy, and almost three times higher than the expected incidence among women of similar age in the general population. Eighty per cent of the psychiatric referrals occurred within two years of hysterectomy. The most frequent psychiatric symptom was depression.

The incidence of psychiatric referral after hysterectomy was more than twice as high among patients without significant pelvic pathology as among those with significant pathology. Fifty-seven per cent of all patients with a previous psychiatric history were re-referred after the operation. Thirty-five per cent of all women who were separated or divorced at the time of operation were referred to a psychiatrist after hysterectomy.

It is suggested, therefore, that there are certain patients on whom a hysterectomy should be performed only after much thought and perhaps only after psychiatric assessment. This would be the case where the patient complained of menorrhagia or pelvic pain, and where there was no anemia or significant finding either on pelvic examination or on curettage, especially if the patient had had a previous psychiatric referral or had a history of marital disruption.

As somatic symptoms are often features of a depressive illness, attention should be paid to both physical and emotional complaints, particularly exhaustion, the recurrence of somatic symptoms, nervousness, and depression. In all such cases the patient should be specifically questioned about depression of mood and other depressive symptoms, and a psychiatric opinion sought if necessary. — Montagu G. Barker, M. B., M. R. C. P., Dundee, Scotland: *British Medical Journal*, 2:91-95, April 13, 1968.

The Management of Depression in Children and Adolescents

WILLIAM M. EASSON, M.D.

DEPRESSION, the experience of disabling sadness, is a nonspecific symptom common to many emotional disorders in children and in adolescents. The manifestation and the expression of the depressive emotions depend on the underlying etiologic features, on other coexisting emotional symptoms, and on the maturity and the personality integration of the child or the teenager. In any antidepressive regimen, it is essential to clarify as far as possible the specific depressive disorder. Purely symptomatic treatment of depressive symptoms may be directly harmful at times; treatment specifically directed toward one depressive syndrome may have little therapeutic value or may be actually injurious if used in a different depressive illness. The first stage in management is to classify the type of illness.

Depressive syndromes in young patients, as in adults, can be separated into three major clinical groups:

(a) The endogenous depressive syndrome, where the main etiologic factors have a physical-constitutional basis.

(b) The reactive depressive syndrome, in which the depression is a reaction to experienced loss.

(c) The symptomatic depressive syndrome, where the depressive symptoms are merely part of a more pervasive emotional disorder.

Though these depressive syndromes overlap widely, it is useful to consider and to treat depressed children and adolescents as they fall into these diagnostic categories. Depressive symptoms in the child and the adolescent are demonstrated in a fashion less integrated, less static, and less consistent than in the adult. As the child grows to adulthood, the way he experiences and shows depressive feelings will change markedly until it approaches the usual adult pattern.[1] The less mature the child is, the less capable is he of experiencing depression in a mature fashion or of sustaining depressive feelings.

Presented at the meeting of the Toledo Academy of Medicine, October 15, 1967. Submitted January 5, 1968.

The Author

● **Dr. Easson, Toledo, is Professor and Chairman, Department of Psychiatry, Medical College of Ohio at Toledo.**

The Endogenous Depressive Syndrome

In this group of patients, we deal with children and with adolescents whose basic personality is still intact. These children are able to relate meaningfully to those around them but they are suffering from excessive and disabling feelings of sadness. In these patients, a deep pervasive feeling of sadness arises with little or no environmental precipitation but is caused rather by inherent constitutional, physical, and hormonal factors. Many authors[2] have suggested that endogenous depression is rare before adulthood yet all of us are familiar with the moody, sensitive adolescent. Without obvious reason such a teenager may become sad and apathetic; during the depths of this sadness, the young man or the young woman may be hopeless, weepy, and irritable. Such moodiness, the essence of the endogenous depressive syndrome, is taken almost as normal during adolescence. Rarely do we see such adolescents in treatment because typically these depressive syndromes are short lived — the teenager, who swings into a "blue" mood, characteristically swings out of this depression quickly. Even the profoundly depressed adolescent does not present for treatment because the depression is relatively brief or because he tends to act out his depressive feelings. If the young girl feels worthless one day, she feels better next morning or she can act out her worthlessness by being promiscuous; if the young man feels "what's the use," he will be more hopeful next day, or he can put an even heavier foot on the automobile accelerator that evening. Sometimes, however, these adolescent endogenous depressive syndromes are more persistent or recur in a more disabling fashion. The adolescent may continue sad, weepy, droopy, and

hopeless. He may be apathetic and numb, beset with thoughts of suicide. The teenage girl may find that her depressive feelings become disabling around the time of her menstrual period. The boy may become increasingly withdrawn and obtunded in the school classroom setting. Such adolescents can become increasingly involved in self-destructive or antisocial behavior.

Since this depressive syndrome is precipitated by physical and constitutional factors, the optimum treatment program is somatically directed. For the most profoundly depressed patients with an endogenous depression, the patients who are so depressed that they are immobilized or suicidally hopeless, six to ten electroconvulsive treatments in a hospital setting provide the treatment of choice. Where the depressive symptoms are less profound and the patient is still mobile and functioning in society, a course of antidepressant medication may be tried under close medical supervision. The doctor should familiarize himself with one or two antidepressant drugs so that he has maximum therapeutic flexibility with these medications. Imipramine (Tofranil®) or amitriptyline (Elavil®) are often therapeutically satisfactory in the endogenous depressive syndrome, inasmuch as they relieve both depressive and anxiety symptoms with a low degree of toxicity and side effects. Children and adolescents tend to respond more actively to the antidepressant drugs so the dose level is lower than the corresponding adult levels. For an adult sized adolescent patient, a total dosage of 50 to 75 mg. imipramine divided over the day is the most common treatment regimen. If this total daily drug intake is considered as given to a 150 pound subject, the corresponding dosage level for a smaller child can be gauged approximately by giving a daily total of ⅓ to ½ mg. imipramine per pound body weight divided in three doses over the day. This level of drug intake may provide too high an initial dosage level so it is useful to start with approximately two thirds of this amount, divided in three doses over the day and increase and decrease the dosage depending on the therapeutic effect and on any side effect. For a 90 pound child the initial dosage level could be 10 mg. three times a day with increase or decrease depending on therapeutic effects or signs of toxicity. The dosage of amitriptyline tends to be 70 to 100 per cent of the imipramine dosage level. The main drawback of this antidepressant medication is that the symptomatic improvement may not occur for two or three weeks.

The depressed adolescent must be watched very carefully, as he is liable to act out his depressive symptoms. The risk of suicide increases as the teenager begins to rouse from his depressive apathy. As he becomes more active, he is then more liable to be involved in accidents, antisocial behavior, or suicide. If there is a risk of such self-destructive behavior, the patient should be hospitalized for his own protection and for the protection of society. Psychotherapy alone does not benefit the patient with an endogenous depression; indeed, such kind understanding is liable to make the hopeless, depressed patient feel even more worthless and undeserving of such warmth. A firm kindly attitude should be, of course, maintained during the whole treatment program but with these patients the main therapeutic approach is directed toward the underlying somatic features.

The endogenous depressive syndrome, while infrequently recognized clinically in adolescents, is even less often diagnosed in preadolescent children. Undoubtedly there is a group of young children who show periods of moodiness, irritability, and retardation of functioning due to constitutional and physical factors. Frequently such syndromes can be recognized historically in adult patients who develop endogenous depressions. It is likely, both with preadolescents and with adolescents, that if such a depressive syndrome is allowed to persist, there will be permanent growth stunting both emotionally and intellectually. Much more work clinically and diagnostically needs yet to be carried out with this group of constitutionally based depressed patients.

The Reactive Depressive Syndrome

This is by far the most common depressive syndrome diagnosed and described in children and adolescents.[3] Since the depressive symptoms are often overshadowed by manifestations of personality disruption, this syndrome may present with a wide range of clinical patterns. The reactive depressive syndrome is an excessive and disabling reaction to a felt and experienced loss. These children are able to relate to family, friends, and to their environment. Their personality is intact but their emotional integrity may be impaired by the emotional loss, which precipitates the depression. This depressive syndrome occurs at all age levels but the symptomatic expression is dependent on the emotional maturity and personality integration of the growing child. With a child or adolescent, significant relationships with family, with friends, or with the environment serve two distinct essential purposes: (1) these relationships provide emotional gratification and (2) they also give continued necessary external personality integration and stabilization. Since the relationship is gratifying and pleasurable, the relationship loss is a loss of pleasure. For all children and adolescents, significant relationships also provide outside emotional support and direction; the child or adolescent is dependent on these relationships to direct him in making proper decisions and to help him control his inner feelings and drives. Without these meaningful relationships, until he reaches adult emotional maturity and self-sufficiency, the growing child or teenager may lack the ability to cope with even the ordinary demands of everyday living. The loss of a significant relationship may leave the adolescent or the child unable to cope with his own

impulses or to make appropriate day-to-day decisions. Without the environmental strengthening and direction provided by basic significant relationships, the child may be unable to function and to grow; the resultant personality disruption and anxiety may totally cover over any depressive mourning reaction to the loss of a gratifying relationship.

With younger more immature children, the loss of a meaningful relationship is most liable to precipitate personality disorganization. This emotional disruption has been described frequently in the child who is hospitalized,[4,5] who has moved from a familiar environment, or who has suffered the loss or the death of a meaningful family member. Where the young child's hope or the adolescent's dreams are stripped from him by disfigurement,[6] by chronic illness,[7] or by the bewildering threat of death, the emotional reaction may be a withdrawal due to emotional overburdening rather than depression due to grief. Social demands separate young children and adolescent from meaningful relationships when they go to public school,[8] when they are sent to camp, or when they are drafted into the armed services. A parent may become emotionally unavailable to the child because of the parent's own depression or illness. The more meaningful the loss or the more immature the child suffering the loss, the more liable is there to be a panicky emotional disruption rather than a more controlled adult-style depressed grief reaction. The older the child and the stronger he is emotionally, the better he is able to tolerate separation from outside emotional supports and the more liable then is he to present with an overt depressive reaction of mourning and sadness over the loss of a meaningful relationship.

Since this reactive depressive syndrome is a reaction to a psychological loss, the treatment is directed to compensate for this psychological deprivation. In the very young child the depressive disorganization can be treated only by the return of the specific loved person, usually the mother. It may be necessary to allow the mother extensive visiting privileges while the child is in the hospital. In slightly older children, substitute caring people may be accepted—a brother, a sister, an aunt, or a warm, caring nurse. The teenage child is more able to use peer group support or even symbolic emotional objects such as letters or photographs to provide the needed emotional stabilization and compensation for the emotional loss. Where such outside emotional support is provided either by the return of the parent or by caring-treating personnel, the child's symptomatic picture frequently does not improve but often indeed becomes worse. When external emotional support is provided so that the child can reorganize emotionally, the child or the adolescent is then capable of facing the emotional reality of the loss of a pleasurable, gratifying relationship. The young patient may then erupt in a sad, angry mourning reaction. Once the young draftee becomes comfortable with his buddies, he may disintegrate into profuse weeping. Once the young patient in a hospital becomes secure with a friendly nurse, that patient may become a nasty, angry, irritable, irritating child. When the child or adolescent is provided with and can use outside emotional support to help himself reintegrate emotionally and face his emotional loss, only then are we liable to see in these children the anger and the sadness of the normal mourning separation reaction.

The treatment of such mourning, anger, irritation, and depression is the treatment of all mourning reactions. Further and continued substitute relationships need to be provided to compensate for the emotional loss, while at the same time the child must be given suitable, appropriate outlets for the natural anger and bitterness at the loss. Treatment team members must watch lest they tend to withdraw when the child begins to show the anger of the mourning process. These children and these adolescents need to be allowed to work out their frustration and their anger at losing a familiar, warm, and pleasurable relationship in a socially acceptable growth producing, nondestructive fashion. The doctor who is dealing with such a reactive depressive syndrome needs to be able to help the young subject to vent his angry tensions through active, forceful pursuits such as intense aggressive intellectual competition or hard physical work. A warm, supportive, psychotherapeutic approach should help compensate at least in part for the loss of the warmth and the stability of a meaningful relationship. Psychological support and strengthening thus has to be provided on two levels for these patients—to bring about emotional stabilization and reintegration and then to help the patient deal with the profound mourning reaction to the loss. In the treatment of child and adolescent patients with a reactive depression, it is sometimes difficult to sustain the treatment program because of an overt symptomatic worsening as the treatment takes effect. It must be remembered that before the child or adolescent is fully able to experience and to react to a grief-separation reaction he needs first psychological support and strengthening to reestablish and to maintain his emotional integrity.

Medication may be helpful for various aspects of this reactive depressive syndrome. If the child has become disorganized due to the anxiety over the loss of outside emotional support and direction, a tranquilizing drug may so lower the level of tension that the patient may be able to integrate emotionally. With such patients it then may appear that the tranquilizer has precipitated a depression but in reality the ataractic has merely helped the patient reorganize emotionally so that he could then face the emotional meaning of his loss and, in such an instance, become depressed over the loss. With such patients, the tranquilizing medication should not be stopped then but rather the overt depression should be treated

also. Many children and adolescents are made anxious by an open psychotherapeutic approach. The use of an antidepressant drug may cause some moderate symptomatic relief but may also allow the doctor to give continued psychological support and direction while prescribing and supervising a course of medication. As these patients with a reactive depressive syndrome become more organized and more able to face their feelings of loss, antisocial and suicidal behavior may occur and may necessitate temporary hospitalization. In a reactive depressive syndrome, the patient struggles with angry as well as sad feelings; such anger may become self-directed in a self-punitive or suicidal fashion or environmentally directed in antisocial delinquent behavior. The child or the adolescent may have to be protected and controlled against such symptomatic expression until other therapeutic measures have been able to alleviate the patient's inner tensions and conflicts.

The Symptomatic Depressive Syndrome

Where depressive symptoms are merely part of a more pervasive emotional disorder such as a psychosis or a character disorder, the treatment of such patients is directed towards the total emotional illness. In all depressive syndromes, it is essential to have a clear diagnostic evaluation to ascertain that the patient does indeed have a solid personality core and a continued ability for meaningful relationships. Where it is shown that the patient lacks personality integration and where there is a diffuse emotional illness, symptomatic treatment of depressive symptoms may be untherapeutic. Where the child or adolescent is confused, subject to disruptive emotional impulses, and liable to psychotic breaks with reality, his most effective emotional defense may be to be depressed and withdrawn. Such a depression may insulate him from being faced with decisions he cannot make or from facing feelings with which he cannot cope. Any treatment which relieves the depression in such patients may push them into situations which they cannot handle resulting in more profound personality disruption.

In clinical practice these diagnostic groupings overlap. In the depressive syndromes the specific treatment program should be flexible so that the patient can be helped with the causative factors as they arise. Thus in certain patients after the constitutional-somatic factors are treated, psychological causes may arise or may become important so that the treatment approach then becomes much more psychologically directed. Above all it is important to be aware that disabling depressions do occur in children and in adolescents, that such depressive syndromes occur under different guises depending on the child's level of emotional development and on the etiologic factors, and that treatment must take into account these causative factors and the emotional capabilities of the patient.

Summary

Depressive symptoms, though infrequently diagnosed and even less frequently treated, are not uncommon in children and adolescents. Due to the personality immaturity of these subjects, the depressive syndromes do not present with a typical adult symptom pattern. An optimum treatment program must take into account not only the patient's level of emotional growth but also the differing etiologic factors. While there is much overlap, it is helpful to plan a treatment regimen to deal with the most important causative factors.

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A REFERRAL TO A PSYCHIATRIST may be beneficial to a patient with an emotional disorder, but to a large extent the effectiveness of a referral depends upon how it is made and the relationship between the referring doctor and the psychiatrist. Constant vigilance is necessary to insure that this relationship is unencumbered with hostility and disagreements between the referring doctor and the psychiatrist. The best way to insure this is frequent communication between doctors, preferably by personal communication. The psychiatrist can promote this by becoming involved in treatment of patients in the general hospital. Other doctors can promote this by a better understanding of the referral process. — David H. Smith, M. D., Wheeling, W. Va.: *Southern Medical Journal,* 59:779-781, July 1966.

Carcinoma of the Thyroid

ROBERT K. FINLEY, JR., M.D.

IS a more radical operation or more conservative one better for cancer of the thyroid? To answer this question a 13-year follow-up of patients treated for cancer of the thyroid is presented. All patients who have cancer are reported to the Montgomery County Society of Cancer Control, where a central cancer registry is maintained. Thirty-three patients were registered with cancer of the thyroid and have been followed more than 13 years. The cases were divided into papillary and nonpapillary cancer of the thyroid. The slides were reviewed and classifted by Dr. James Funkhouser, pathologist at Miami Valley Hospital. There were ten patients in the nonpapillary group, which included follicular, medullary, spindle giant cell, and Hurthe cell tumors. There were 23 patients with papillary cancer (Table 1).

There were 83 per cent females in the papillary group while in the nonpapillary group 40 per cent were female (Table 2). The sex distribution is essentially the same as for all thyroid diseases. The age of the papillary group averaged 36 years, with a high of 67, and low of 12. The nonpapillary group averaged 42 years, with a high of 66, and low of 8 (Table 3).

TABLE 1. *Thyroid Cancer — Papillary and Nonpapillary*

	33 Cases
Papillary	23
Nonpapillary	10

TABLE 2. *Thyroid Cancer — Sex*

	Male	Female
Papillary	4 (17%)	19 (83%)
Nonpapillary	6 (60%)	4 (40%)

TABLE 3. *Thyroid Cancer — Age*

	High	Low	Average
Papillary	67	12	36
Nonpapillary	66	8	42

Submitted January 23, 1968.

The Author

● **Dr. Finley, Dayton, is Instructor in Surgery, Ohio State University College of Medicine, Columbus; Chief, General Surgery Section, Miami Valley Hospital; member of the Courtesy Staffs, Good Samaritan, Kettering Memorial, and St. Elizabeth Hospitals, Dayton; and Consultant at the Dayton Veterans Administration Hospital.**

Operation and Results

Twenty-three patients with papillary cancer have been followed for 13 years (Table 4). The adenoma was resected three times with one death. A lobectomy was done four times and no deaths occurred. Subtotal thyroidectomy was done six times and no deaths occurred in the followup period. A total thyroidectomy was done twice and one death occurred. A thyroidectomy with resection of neck glands was done eight times and two deaths occurred.

Deaths

There have been four deaths in the papillary group during the past 13 years. One patient died eight years postoperatively of a pulmonary embolus arising from a clot in the left leg. One patient died two years postoperatively of unknown causes, presumably from cancer. One patient, who had widespread disease at the time of surgery, died one month postoperatively. She had infiltration of the lungs, mediastinum, trachea, and esophagus. A tracheostomy and gastrostomy were done after a thyroidectomy was carried out. She gradually deteriorated and died of her disease. One patient died of a blood transfusion reaction during surgery.

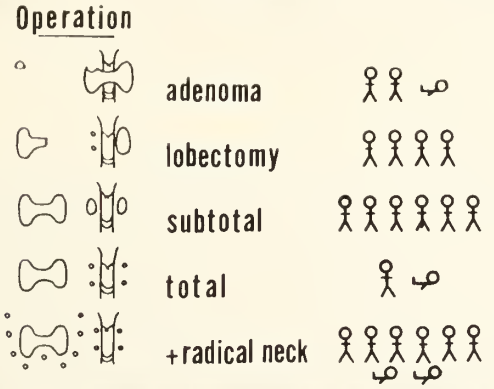
Patients Having Nodal Excision Done

Eight patients had a thyroidectomy and some form of nodal excision. Two of these patients have died. One received incompatible blood during surgery, and one had widespread disease and gradually deterio-

rated postoperatively. All eight had cancer present in grossly involved nodes at the time. Three patients are receiving thyroid hormone and had x-ray therapy

TABLE 4. *Thyroid Cancer — Papillary*

23 Cases

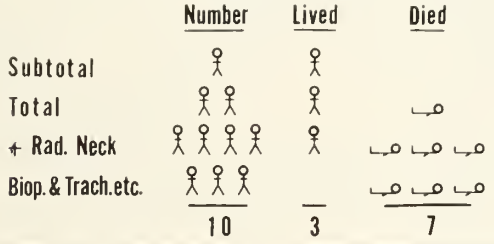


and two had I^{131} in addition to the thyroid hormone. Six of these patients remain well after 13 years.

The nonpapillary group shows little effect of treatment on the course of their disease. (Table 5). A subtotal thyroidectomy was done once and this

TABLE 5. *Thyroid Cancer — Nonpapillary — Operations*

10 Cases



patient has survived. Two patients had a total thyroidectomy done and one died. Four patients had a thyroidectomy plus a radical neck dissection and three died. Three operations included a tracheostomy and biopsy and these three died. Table 6 shows the summary of the mortality with these two diseases.

Discussion

Results of the surgical treatment of carcinoma of the thyroid are good. The logic of the operation proposed is often confused in the mind of the surgeon and practitioner alike. In this reported group of patients, many types of operations performed seemed to have a good result in the treatment of the disease.

It is logical to remove all the cancerous tissue present in any type of carcinoma. But how much of

TABLE 6. *Thyroid Cancer — Mortality*

	Lived	Died
Papillary	19	4 (22%)
Nonpapillary	3	7 (70%)

an operation is necessary to remove all the effectively growing cancerous tissue? Clark[1] has documented the frequent occurrence of multicentric cancer in thyroid glands. Multiple whole gland sections show that areas of cancer are in the opposite lobe or isthmus in almost 90 per cent of the specimens studied. Black[2] has reviewed 328 specimens of papillary carcinoma from Mayo Clinic (1940 to 1954) and found multicentric origin in 20 per cent, but these are not whole gland sections—not completely comparable studies. There is, however, good evidence now that in some cases the cancer starts in different places, and removing just one lobe may leave some cancer behind. However, the results of removing the lobe which contains the nodule plus the isthmus are so good that this seems to be the procedure of choice.

Secondly, lymph nodes may be involved in papillary cancer of the thyroid. Frazel[3] found 70 per cent of the patients followed for the past 25 years had nodal involvement. In this reported group, when the nodes were removed, they were involved. Yet in both instances the survival is high. There is no other cancer that acts in this way, since nodal involvement usually means a poor prognosis in most cancer except papillary carcinoma of the thyroid.

The striking difference in prognosis of papillary cancer in contrast to the nonpapillary group is shown in this study. The diagnosis of papillary carcinoma of the thyroid has a very good prognosis.

Summary

Papillary cancer of the thyroid has a good prognosis and seems best treated with a wide local excision. Positive nodes do not preclude a long survival in the papillary group. Nonpapillary cancer of the thyroid has a poor prognosis with any form of therapy.

Acknowledgment: I wish to acknowledge the help of Dr. James Funkhouser of Miami Valley Hospital in interpreting the pathology slides in this study. Secondly, I wish to acknowledge the help of the staff of the Montgomery County Society for Cancer Control in the follow-up of these cases.

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Intracranial Aneurysm

Report of a Case with 17-Year Survival after Treatment by Carotid Ligation and Obliteration by Packing.

OSCAR A. TURNER, M.D.

METHODS for control of bleeding from intracranial aneurysms range from simple ligation of the carotid artery in the neck[1] to reinforcement of the aneurysmal wall by plastic coating[2] when placement of a clip across the neck of the aneurysm is not feasible. The present case is reported because of interest in that it represents no unorthodox procedure wherein the combination of packing of the aneurysm cavity and carotid ligation resulted in a 17-year survival.

Case Report

The patient was a 56-year-old woman seen first in August 1951 with a complaint of diplopia of two to three months' duration. There was a history of visual difficulty of a vague nature, relating to visual impairment and conjunctival congestion for three years. In June 1951 she experienced an episode of vertigo and at this time the right pupil became dilated and fixed, while ptosis of the right lid developed one week before consultation. There had been some dull aching pain in the right eye for several days and she had occasional lightheadedness of recent origin. The patient was right-handed.

Examination revealed a dilated right pupil, which was fixed, and partial ptosis of the right lid with associated loss of upward rotation of the globe. The right corneal reflex was depressed and there was slight impairment of sensation in the distribution of the first division of the right trigeminal nerve. Neurologic examination was otherwise normal. The blood pressure was 145/95.

The clinical diagnosis was that of an aneurysm of the intracavernous portion of the carotid artery and the patient was admitted to the hospital for further study.

X-rays of the skull showed some general demineralization, a normally positioned pineal gland, and a normal sella turcica but an abnormally large and irregular superior orbital fissure on the right. Lumbar puncture revealed clear fluid under normal pressure, containing no cells and 36 mg./100 ml. protein. X-rays of the chest were suggestive of atelectasis of the middle lobe of the right lung, but bronchoscopy followed by a bronchogram disclosed only poor aeration with no other pulmonary abnormality. An operative right carotid arteriogram visualized a large aneurysm situated lateral to the sella turcica, the aneurysm measuring 2 cm. in diameter on the x-ray film (Fig. 1). Ligation of the right common carotid artery was done following arteriography.



FIG. 1. *Preoperative arteriogram showing large aneurysm adjacent to sella turcica.*

About ten days after carotid ligation a right frontotemporal craniotomy was performed. In the middle fossa, occupying the position of the anterior third of the temporal lobe, was a large globular mass, the exposed portion of which measured 3 to 4 cm. in diameter. The mass was firmly fixed and appeared to be attached to the dura mater at the base, compressing and displacing the anterior portion of the temporal lobe as far back as the sylvian

The Author

● Dr. Turner, Youngstown, is Chief, Neurological Surgery, The Youngstown Hospital Association.

From the Division of Neurosurgery, The Youngstown Hospital Association, Youngstown, Ohio. Submitted April 23, 1968.

lip. The lesion had the appearance of a large aneurysm and it was felt that an attempt at removal would result in considerable destruction of brain tissue as well as serious interference with the middle cerebral artery circulation. Aspiration gave no blood until an 18 gauge needle was used. Accordingly, through a small incision in the capsule, laminated clot was carefully curetted and several pieces of Gelfoam® soaked in prothrombin and coated with tantalum powder were packed into the aneurysmal cavity (Fig. 2A and B). Three fine sutures were used to close the opening.

The postoperative course was complicated by pneumonitis. At the time of discharge from the hospital on the ninth postoperative day, she had only occasional discomfort in the right eye but there was no change in the third nerve paralysis.

The patient was seen yearly for the next ten years with no major complaints and with no change in the third nerve paralysis. In 1964 she was treated

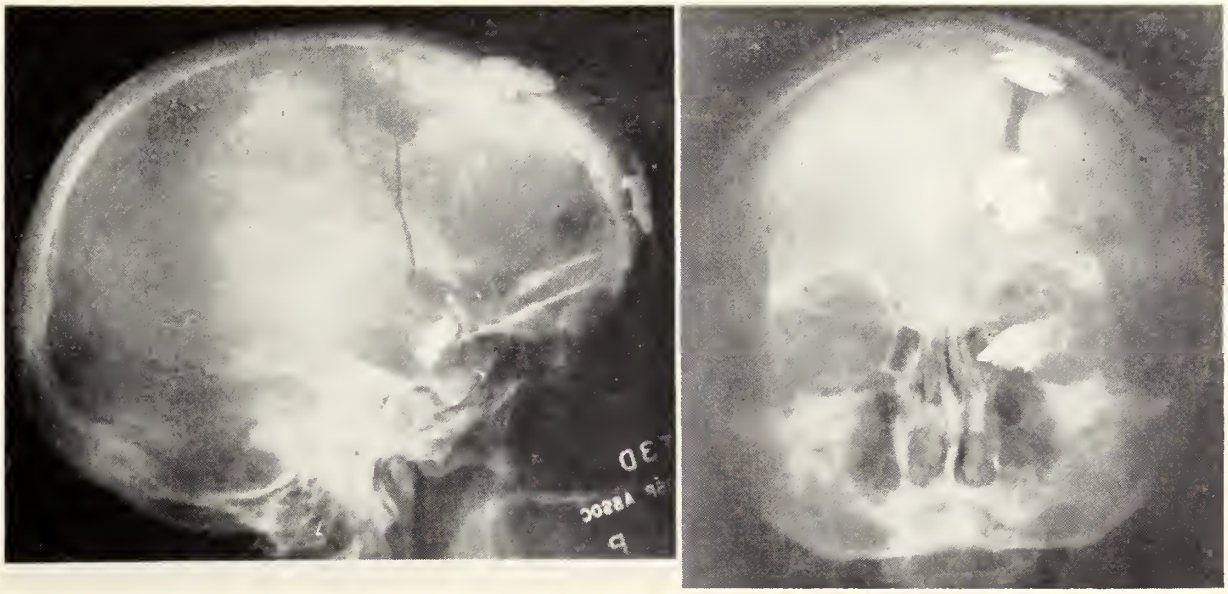


FIG. 2 (A and B). *Postoperative x-rays showing location of tantalum powder in aneurysmal cavity.*

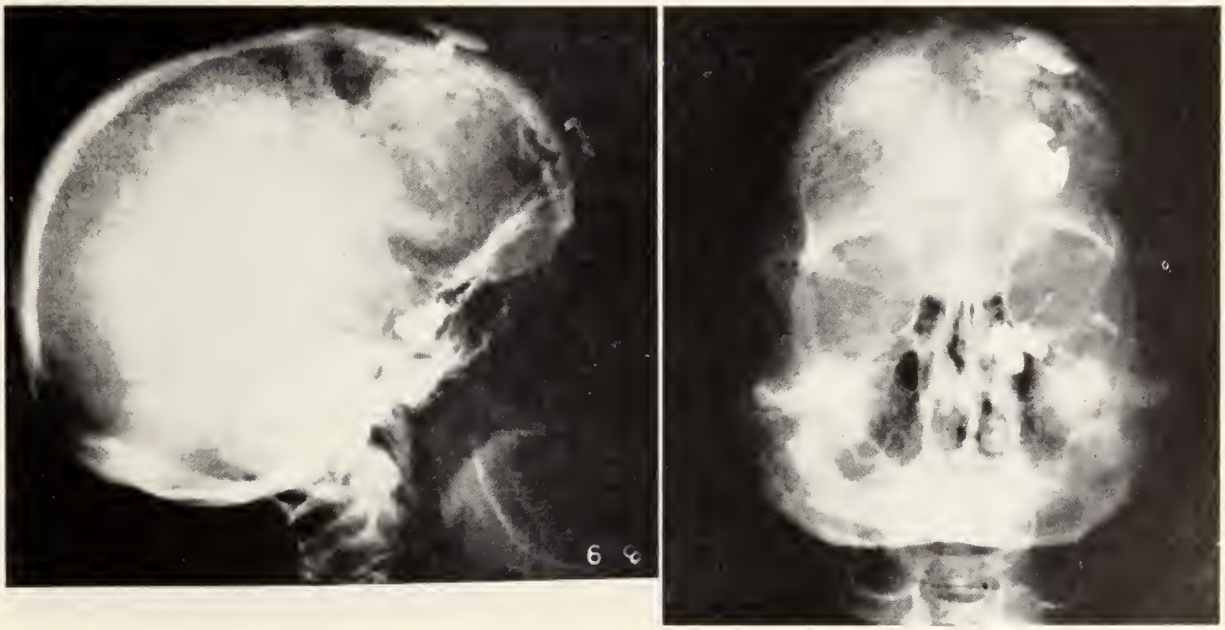


FIG. 3 (A and B). *X-rays of skull taken 17 years after operation showing little change in the distribution of the tantalum powder.*

for what appeared to be labyrinthine vertigo, this responding well to medication. At this time, examination disclosed no essential change in her neurologic status. Examination at my request in February of 1968 revealed marked improvement in the ptosis. Trigeminal nerve function was intact but a complete external and internal ophthalmoplegia existed. X-ray examination of the skull at this time disclosed no significant change from the postoperative findings in 1951 (Fig. 3A and B).

Discussion

Carotid arterial ligation is accepted as a reasonably benign and effective treatment for aneurysm of the intracranial portion of the internal carotid artery.[3] However, at the time arteriography was done in the present case the technic and instrumentation were less than satisfactory and, in view of the large size of the lesion, direct attack was decided upon. The aneurysm described here undoubtedly does not approach the so-called "giant aneurysm" described by Sadik, et al,[4] but it is of interest that these authors describe incision through the capsule and removal of some of the contents of an aneurysm, which at autopsy measured 8.5 x 5.5 x 5 centimeters. Orbital pain, considered by some as probably indicating enlargement of the aneurysm within the cavernous sinus,[5] was relieved by the operative procedures, but it is of importance to recognize that therapeutic collapse of an intracavernous aneurysm may also give rise to untoward symptoms.[6]

While the response of tissue to tantalum sheet has been shown in early studies to be minimal, later investigators found that tantalum powder, particularly of larger particle size, does cause a significant fixed tissue response.[7] Because of this, it was felt that the use of tantalum powder would not only visualize the lesion but would aid in the obliteration of the aneurysmal cavity. It is not known if carotid ligation alone would have resulted in the present length of survival, but the tantalum powder has permitted radiologic follow-up indicating no essential change in the aneurysm.

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CARDIAC WORK TEST UNIT — Physicians now may test their ability to determine safe work levels for cardiac patients through use of a table-top unit prepared by the American Heart Association.

Entitled "Work Prescription for Heart Patients," the unit is intended for use at medical meetings and as a teaching exercise for medical students and house officers. It consists of four easily handled panels, three of which illustrate medical case histories and pertinent laboratory data. The fourth panel shows average work equivalents of various jobs. After studying each panel, the physician fills out a multiple choice questionnaire. An answer sheet is provided to check accuracy.

Each panel measures 24 inches long by 34 inches high and fits a standard exhibit frame. The units may be obtained through local Heart Associations. — Ohio State Heart Association, 10 East Town Street, Columbus, Ohio 43215.

Fibromyxoma of the Kidney

Report of a Case Associated with Hypertension

CHESTER R. NUCKOLLS, M.D., VITUS F. PEKAREK, M.D., CREENA VERGHESE, M.D., and ABDUL F. NAJI, M.D.

SMALL FIBROMAS are not infrequent incidental findings in the renal medulla. They do not exceed 10 mm. in diameter.[1] Rarely are larger fibromas found in the kidney. Some of the larger fibromas may show myxomatous degeneration. Hamartomas may contain, in addition to fibrous tissue, other structures such as smooth muscle, vascular channels, fatty tissue, etc. In 1952 Spillane et al[2] collected 18 cases of fibromyxolipoma of the kidney and added one of their own. Allen[3] also mentions that fibromas are not uncommonly found as grayish-white, single nodules, usually 3 to 5 mm. in diameter. As a rule they are located in the medulla. Gordon and Taylor[4] reported a case of renal fibroma weighing 22 pounds.

Albrecht[5] chose the medullary fibroma as a typical example of hamartoma. Impressed by the large number of tubules present in the connective tissue stroma, Albrecht wrote: "There can be no doubt that we are dealing with true hamartomas, tumor-like malformations that deviate from the normal only in the abnormal quantity of connective tissue." However, some investigators regard the medullary fibroma as preneoplastic change characteristic of aging and comparable to senile keratosis in the skin.[6]

Case Report

A 53 year old white male was admitted to the hospital for the first time on August 3, 1963 with the chief complaint of episodes of bitemporal headaches of four months duration. During this time his blood pressure had been slightly elevated.

In October 1953, during the course of a routine physical examination, his blood pressure was recorded as 145/90 mm. Hg. At that time he gave a history of attacks of bronchial asthma, which were eventually traced to orris root and a pyrethrum ingredient in the talcum powder he was using in his barber shop. After eliminating these two substances from the talcum, he had very little difficulty. In May 1963 he began to complain of headaches.

Physical examination was essentially negative. There was no cardiac enlargement and the urine revealed no significant positive findings. Blood pressure was 160/100 and pulse 80 beats per minute. He was placed on treatment with a low salt diet and Diupres®, 250 mg. twice a day. Two weeks later his blood pressure was 128/80 mm. Hg. He was then advised to take Diupres (250 mg.) once daily.

In July 1963 his blood pressure was 160/100 mm Hg. At that time he was hospitalized, and a routine work-up revealed a lesion of the right kidney.

Physical examination revealed a well-developed and well-nourished adult male with no remarkable physical findings other than blood pressure of 170/100 mm. Hg. Temperature was 98.6°F, pulse 80 beats per minute.

Repeated urine examinations revealed no pathologic findings. There was normal specific gravity, averaging 1.011, with no protein or cellular deposits. Serology test was negative. Hemoglobin was 16 Gm.; hematocrit 44 per cent. White blood cell count was 7,000 with differential 58 per cent polys, 32 per cent lymphs, 7 per cent monos, and 3 per cent eosinophils. Blood phosphorus was 3.6 Gm. per cent, alkaline phosphatase 3.6 units, and blood urea nitrogen

Submitted March 21, 1968.

The Authors

- Dr. Nuckolls, Cleveland, is Chairman, Department of Urology, St. Alexis Hospital; and a member of the Staffs of Marymount, Lutheran, Grace, and St. Johns Hospitals.
- Dr. Pekarek, Cleveland, is a member of the Active Staff and Associate Staff in Surgery, St. Alexis Hospital.
- Dr. Verghese, Cleveland, is Fourth Year Resident in Pathology, St. Alexis Hospital.
- Dr. Naji, Cleveland, is Clinical Instructor in Pathology, Case Western Reserve University Medical School; Director, Division of Laboratories, St. Alexis Hospital; Director of Laboratories, St. Ann Hospital; and Visiting Pathologist, Metropolitan General Hospital.



FIG. 1. *Ascending pyelogram showing elongation and compression of the proximal caliceal system of right kidney.*



FIG. 2. *Surgical specimen. Right kidney showing a spherical tumor mass of upper portion, causing compression of the proximal caliceal system.*

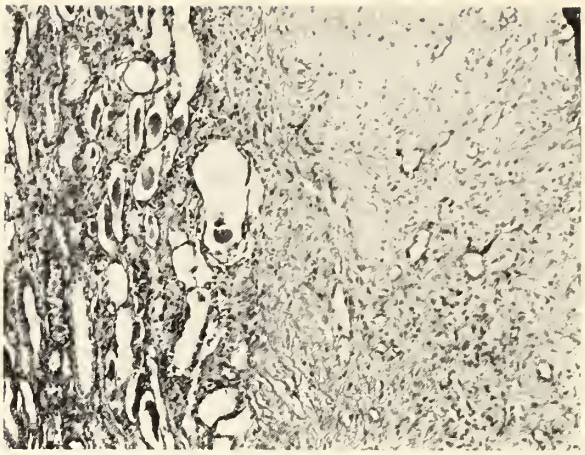


FIG. 3. *Photomicrograph. Junction of tumor with renal parenchyma. The tumor is well circumscribed but exhibits no prominent capsular structure.*

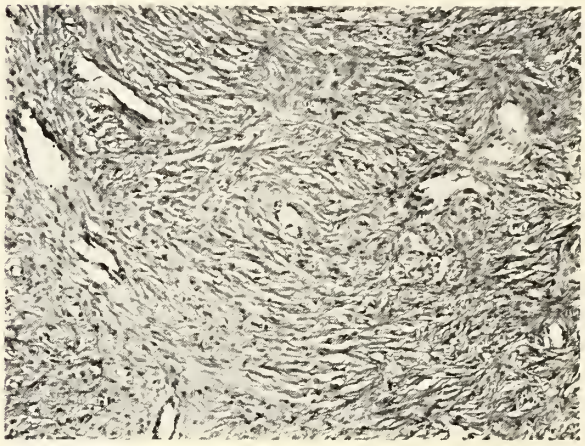


FIG. 4. *Photomicrograph. Fibromatous zone of the tumor.*

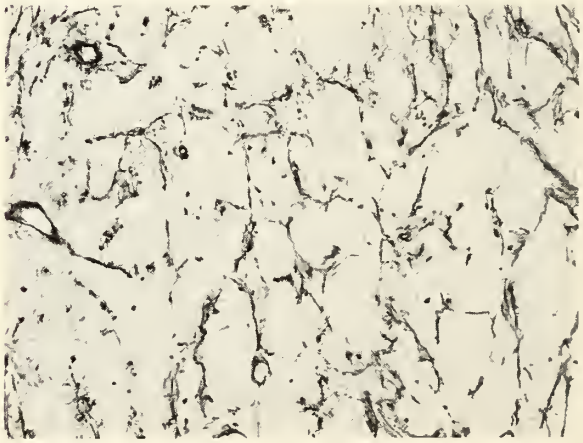


FIG. 5. *Photomicrograph. Myxomatous zone of the tumor.*

(BUN) 16 mg. Urine cultures revealed no growth. Urine catecholamines were 31 ug/24 hr.

Chest x-ray revealed normal lung fields. KUB film showed that the kidney shadows were not well visualized. Intravenous pyelogram showed the dye to appear promptly in both kidneys in five minutes. The left pelvicaliceal system and ureter were well outlined and appeared normal. Marked enlargement of the upper half of the right kidney was noted with lateral deviation, elongation, and rotation of its superior caliceal system. There was no definite notching or invading lesion. The interpretation of the intravenous pyelogram was a large renal mass occupying the upper portion of the right kidney.

Cystoscopy revealed no obstruction of the urethra. There was a Grade I enlargement of the lateral median lobes of the prostate. There was no residual urine and no mucosal lesion of the bladder. The urinary bladder capacity was 250 cc. Both ureteral orifices were normal. Catheterization of both ureters up to the pelves was performed without difficulty. Indigo carmine appeared within 13 minutes after injections on both sides. Ascending pyelograms showed a normal left pelvis. On the right side the findings were similar to those of the intravenous pyelogram (Fig. 1). Presacral CO_2 insufflation showed no evidence of adrenal tumor.

On August 21, the right kidney was resected without difficulty.

The surgical specimen consisted of a right kidney weighing 390 Gm. and measuring 14 x 8.0 x 5.0 cms. The upper half of the kidney was swollen and measured 8.0 cm. in thickness. The capsule was intact and was separated with ease. The cortical surface was smooth, reddish-brown, and uniform. On section, there was a spherical tumor mass occupying the upper portion of the kidney and measuring 7.0 cm. in diameter (Fig. 2). It was well-defined and sharply demarcated from the surrounding renal parenchyma. The mass had a yellowish-gray cut surface, which was moderately soft, moist, and glistening. The mass stretched and compressed the superior caliceal system. There was no ulceration of the caliceal mucosa and no hemorrhage of the renal pelvis. No evidence of infiltration of the renal parenchyma by the tumor was noted. The rest of the renal parenchyma was intact and appeared to be normal.

Microscopically the tumor was well-circumscribed but showed no capsule (Fig. 3). It was formed of interlacing bundles of long fibers having oval nuclei. Foci of myxomatous spindle cells within edematous background were also noted (Figs. 4 and 5). Occasional areas of hyalinization were present within the tumor. The tumor compressed the surrounding renal tissue without irregular extension. The microscopic appearance of the tumor was consistent with fibromyxoma. The renal tissue was involved by slight focal chronic inflammation.

TABLE 1. *The blood pressure chart during the patient's hospital stay.*

	August	13	170/100
		14	132/76
		15	172/90
		16	156/90
		17	160/80
		19	156/94
		20	176/80
Date of surgery		21	150/88
Postoperative period		22	126/72
		23	124/70
		24	140/85
		25	136/70
		26	150/90
		28	154/84
		29	142/80
		30	144/90
		31	138/80
	September	1	126/76
		2	130/70
		3	120/70

The postoperative course was uncomplicated. Table 1 lists blood pressure record during hospitalization. The patient was discharged on September 3, 1963 in good condition with no urinary symptoms. The urine before discharge was clear and free from infection or cellular deposits.

Since discharge the patient has been asymptomatic. Periodic physical examinations have revealed no pathological findings. The blood pressure has been constant and within 130-140 systolic.

Summary

A case of renal fibromyxoma associated with mild hypertension is reported. The blood pressure has been normal since nephrectomy.

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Liposarcoma of the Spermatic Cord

Case Report

KENNETH F. HAUSFELD, M.D. and ALEXANDER C. GUIRA, M.D.

MALIGNANT NEOPLASMS of the spermatic cord are uncommon. In 1959 Satter et al reviewed the *Quarterly Cumulative Index Medicus* and *Index Medicus* to 1879 and found that over 200 cases of primary malignant tumors of the cord structures, epididymis, and testicular tunics were reported in the literature.[1] Samellas, in 1964, also reviewed the literature and found 112 primary malignant spermatic cord tumors.[2] To these he added the fourth reported case of liposarcoma of the cord, the three previous cases having been recorded by Herbut,[3] Dreyfuss,[4] and Angeli.[5] A review of the literature since 1964 discloses that two additional cases of liposarcoma of the spermatic cord have been published.[6,7] The following is therefore the seventh reported case of liposarcoma of the spermatic cord.

A 52 year old white male was admitted to Akron General Hospital on March 13, 1965 for evaluation of a nonpainful left scrotal mass. He denied having sustained any trauma to the scrotum or having had tuberculosis or any venereal disease. He had become aware of the scrotal mass about six weeks prior to entering the hospital. Physical examination was normal except for the genitalia. Both testes were palpated in the scrotum, but the left scrotum was enlarged by a nontender, nontransilluminating mass measuring approximately 8 x 8 cm. and adherent posterior to the testis. Superior to this was another mass of the same characteristics measuring approximately 2½ x 3½ cm. No inguinal or femoral lymph nodes were palpable, and no hernia was present. The superior mass was attached to the vas deferens. Urinalysis disclosed laboratory findings within normal limits, as were hemogram, blood urea nitrogen, and fasting blood sugar. A roentgenographic examination of the lungs was normal as was an electrocardiogram.

Exploration of the scrotum was performed through a vertical incision. The larger inferior mass was soft and incorporated the entire epididymis. The smaller cephalad mass was adherent to the vas deferens and had a thick capsule. Fatty tissue was abundant throughout the cord. The testis appeared grossly normal. A left radical orchiectomy, with high ligation and excision of the cord, was performed.

Microscopic examination revealed a normal testis and epididymis enveloped with abundant fatty tissue and suggestive varicocele formation. The distribution of the fat was consistent with multiple lipomata (Fig. 1). The cephalad mass presented varying degrees of cellular necrosis. Lympocytes were present in a thickened capsule, and in the surrounding tissue, there was a bizarre cellular make-up with some strap and banjo cells, larger multinucleated cells, and some cells with giant single nuclei. Nucleoli were prominent and mitotic activity was present (Fig. 2). The final diagnosis was differentiated liposarcoma developing in one of several lipomas of the spermatic cord.

Recovery of the patient was uneventful, and he is well and alive without evidence of recurrent tumor three years later.

Discussion

The etiology of liposarcoma is unknown. Since Cloquet in 1819 first recorded a lipoma of the spermatic cord, lipomata have been the most frequently found neoplasm of this structure. Stout states that some liposarcomas may arise in preexisting lipomas,

The Authors

- Dr. Hausfeld, Akron, is Chief of Urology Service, Akron General Hospital; and a member of the Senior Staff, Urology, St. Thomas Hospital.
- Dr. Guira, Akron, is Chief Resident, Urology Service, Akron General Hospital.

Submitted March 1, 1968.

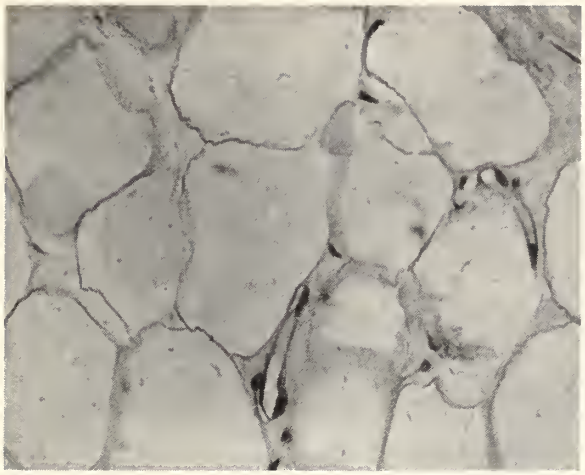


FIG. 1. *Lipoma of Spermatic Cord*

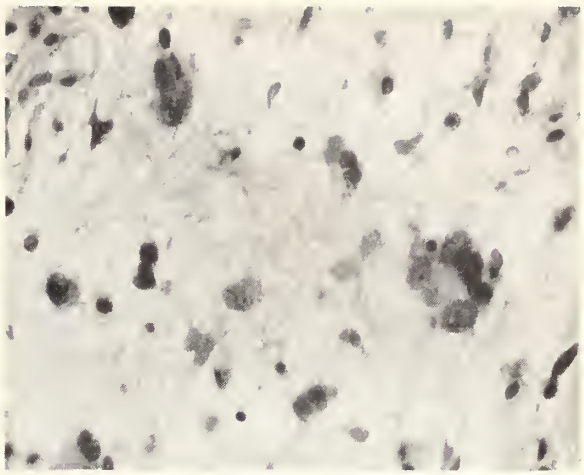


FIG. 2. *Liposarcoma of Spermatic Cord*

but the majority of lipoblastic tumors are malignant from their inception.[8] Caldwell and Zinninger proposed a classification of liposarcoma: 1) lipomyosarcoma; 2) lipoma with areas of sarcomatous degeneration; and 3) true liposarcoma.[9] Our case represents the second classification.

The decreased mitotic activity and the low incidence of liposarcoma, despite the frequency of lipomata of the spermatic cord, agree with Dreyfuss' observation that liposarcomata are the mildest in activity as to recurrence and tendency to metastasize of all the malignancies of the spermatic cord.[4] Once liposarcoma of the spermatic cord is diagnosed, adequate therapy would be radical orchiectomy with high ligation and excision of the spermatic cord without lymph node dissection or irradiation.

Summary

The seventh case of liposarcoma of the spermatic cord is reported. The patient has survived without signs or symptoms of recurrent tumor for over three years. The low grade of malignancy of this neoplasm is emphasized as well as the accepted adequate therapy.

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THE VERY PURSUIT OF RESEARCH, provided that it is relevant, has merit in its own right in creating an atmosphere of intelligent inquiry; but in medicine the practising physician who is intensely interested in the diagnosis and treatment of the individual patient and responds to the challenge which every fresh patient brings has his own constant stimulus to intellectual inquiry and need not be ashamed if he finds the added burden of organized scientific research something of distraction. — Lord Platt, M. D., M. SC., F. R. C. P., London, *British Medical Journal,* 4:441, November 25, 1967.

Maternal Mortality Report For Ohio - 1965*

By the OSMA COMMITTEE ON MATERNAL HEALTH

THE Committee on Maternal Health is pleased to present this ELEVENTH Annual Report for the year 1965. This document is compiled and published in compliance with a House of Delegates directive adopted April 23, 1953, which created the committee, and follow-up action taken by The OSMA Council, January 16, 1954.[1]

Divided into *five* sections, the first division outlines *activities* of your Committee since its last report to The Council on December 11, 1966,[2] when a survey of the *first ten years* of The Ohio Study was summarized.

The second portion describes various *projects* developed and pursued by the committee, fulfilling its prescribed functions.

A statistical summary of The Ohio Maternal Mortality Study* for 1965 is presented in the third section. This summary covers the 88 counties of the state, including figures for patients who died *outside* of hospitals as well as those who died *during* hospitalization. In the fourth portion, the data are analyzed and evaluated for comparison.

In the last section, the Committee advances recommendations based upon experiences with the study and allied facets since its inception.

Activities

Twenty-one members comprise the Committee on Maternal Health. They not only represent the eleven Councilor Districts of Ohio, but also, from their professional attributes, furnish an excellent cross section of general practice as well as the specialties, e. g., obstetrics, gynecology, cardiology, pathology and anesthesiology. Three new members were appointed to the Committee this year, replacing members whose local obligations and commitments prevented a continuance of full participation in committee activities.

Since the last annual report, three meetings have been held by the Committee; two of these were most effective, annual two-day conferences held at the Granville Inn, conducting many items of important business in addition to the review and classification of maternal death cases. In the three meetings a total of 141 cases were carefully studied and classified, using "Guiding Principles for Obstetric Care"[3] as a minimum standard to assess avoidability in each case. In addition, approximately 200 (old) cases were studied individually, during the meeting, to reclassify them as "High Risk Obstetric Patients" (see below).

Throughout the past two years, members have appeared, by invitation, at several county medical society and local group meetings to speak on functions and aims of the committee in its work to reduce maternal mortality and morbidity in Ohio. Material from the Ohio Study has been utilized, also, by members in the instruction of medical students and nurses as well as the lay public.

The Committee on Maternal Health maintains liaison with well-coordinated *County* maternal mortality studies. Six of these are established and operating on an *annual basis* in Cleveland, Columbus, Cincinnati, Dayton, Toledo, and Akron, supported principally by their respective Obstetric-Gynecologic Societies, in cooperation with respective county medical societies. Collateral support is constant between regional studies and the State Headquarters, providing mutual identification of maternal death cases and their thorough evaluation.

Projects

In its advisory function on matters pertaining to maternal health in Ohio, the Committee has worked closely for years with the Ohio Department of Health. One long and tedious project concerning the effective utilization of maternity beds in Ohio hospitals, known by such titles as "Clean Gyn Patients on Maternity Floors," the problem, as a project, has been on the agenda of our committee meetings since

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the state. Since work of the committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

December 5, 1955.[4] After many conferences and two final public hearings, Regulation HE-7-08.01, authorizing the admission of noninfectious gynecologic patients to obstetric beds in Ohio maternity hospitals, was adopted by the Public Health Council and became effective July 1, 1967. The regulation is a part of the Ohio Sanitary Code.

High Risk OB Patient

A comparatively new educational project has been developed by the Committee. During the two-day conference at Granville, January 22-23, 1966 (over two years ago), considerable discussion and a primary interest evolved around "Medical Avoidability" in certain patients who were plagued with "High Risk Conditions" (cardiac disease, diabetes, nephritis, obesity, hemorrhagic disease, etc.) *before* their final pregnancy occurred.[4] Although the approach to the gigantic task of individually surveying over 1,000 cases was somewhat formidable, a subcommittee was appointed to guide the program, and the Committee as a whole, embarked upon the project.

New criteria and nomenclatures ("obesity," weight gain, age, low socioeconomic status, etc.) were established. Approximately 200 (old) cases were studied at one meeting. Promptly it was ascertained that conferences of the *whole* committee were not applicable to the early completion of the project. Thereafter, case reports were mailed in packets of 40 or 50 to members who studied them at home, classified them as to "High Risk Factors" and returned them to State Headquarters. This method proved highly satisfactory as an expedient and also from an economic standpoint.

A rather tedious but rewarding process followed, e. g., transferral of the data onto respective IBM cards. With the highly cooperative assistance of the local Service Bureau Corporation, the second phase of the project was accomplished. The third phase was slightly more tedious; in every "High Risk OB Patient" it was necessary to correlate the high risk condition with the primary cause of death, to ascertain whether or not the former was related to the latter.

After many hours, this phase of the project was completed and the IBM cards on all "old cases" — 1955 to 1965 — were properly marked with a new punch. Now it is possible through data processing to identify and segregate every "High Risk OB Patient" among the 1229 cards in our files! Cases received in the future may be added in our system with minimum difficulty.

Since a national trend is developing a critical focus upon this important phase of obstetric practice, the educational facets of our Ohio Study are augmented tremendously! In the near future articles will appear in *The Journal* bearing data and information obtained from the Ohio Study relative to the "High Risk Obstetric Patient."

In *this* column titled "Maternal Health in Ohio," the Committee continues to publish an article each quarter year (see Table 1). Of necessity, the Committee revised "Guiding Principles for Obstetric Care"[3] including appropriate sections on the "High Risk OB Patient." Two articles from the "Maternal Health in Ohio Column" were reprinted with permission in other medical publications.

TABLE 1. *Publication Date and Subject, "Maternal Health in Ohio Column," OSMJ Quarterly Issues, 1966-1968.*

Date	Subject
Dec. 1966	Maternal Deaths Involving Suicide
Mar. 1967	Maternal Mortality Report for Ohio, 10 Year Survey
June 1967	Maternal Deaths Involving Paralytic Ileus
Sept. 1967	Maternal Deaths Due to Choriocarcinoma
Dec. 1967	Guiding Principles for Obstetric Care (Revised)
Mar. 1968	Maternal Deaths Involving Rupt. Ectopic Pregnancy (Laparotomy)
June 1968	Maternal Deaths Involving Rupt. Ectopic Pregnancy (D. O. A.)

TABLE 2. *IBM Data Processing Projects, By Number and Assignment, 18 Months, 1966 - 1968*

IBM Project	Assignment and Purpose
No. 51	Maternal Deaths, Regional Study, Cleveland
No. 52	Maternal Deaths, Regional Study, Cincinnati
*No. 53	Maternal Deaths in Appalachia (Council)
No. 54	Maternal Deaths Involving Anesthesia (1967 Exhibit)
No. 55	Case Categories for Future Articles (OSMJ)
No. 56a	"High Risk OB Patient" (Preliminary Scanning)
No. 56b	"High Risk OB Patient" 10 year survey (1968 Exhibit)
No. 57	Pelvic Thrombosis, Embolic Phenomenon (Member's Report)
No. 58	Maternal Deaths, Regional Study, Athens County (Member's Report)
No. 59	Annual Report for 1965 (Council — OSMJ)

*(In Preparation)

With this interesting theme, the Committee prepared and displayed an exhibit at the OSMA Annual Meeting in Cincinnati, May 13-16, 1968. Delegates and guests manifested maximum interest in the statistics and lessons portrayed in the production (Booth H-151).

Likewise, the Committee's exhibit, "Maternal Mortality in Ohio — A 10-Year Survey,"[2] displayed May 16-19, 1967, during the OSMA Annual Meeting in Columbus, drew a great deal of interest from observers. As in previous years, the great volume of data required was obtained by using data processing methods.

With a surge of activities engaging the Committee, it was realized that its budget was rather inadequate. The Council approved an increase to $2,000 for 1968. This figure compares favorably with other states.

Numerous other *Projects* have evolved from the use of statistics and material contained in the IBM cards on file (see Table 2) utilizing data processing.

To date, no "project" previously assigned to the Committee by The Council is incomplete!

Statistics for the year 1965 from the Ohio Study are published herewith. They are presented in an uniform manner to facilitate comparison with similar reports issued in the past and with those to appear in the future. Terminology and nomenclature used throughout the study were adopted in 1954, after careful deliberation. They follow closely those prescribed in the *International Classification,* for purposes of uniformity. The reader will note that "High Risk OB Patients" have been designated in each category.

In Ohio, there were 194,927 live births reported during 1965. From this maternal mortality study, the Committee classified 42 *maternal* deaths for the year. The maternal mortality rate was 0.22 per 1,000 live births, or 2.21 per 10,000 live births for 1965.

Discussion

Perhaps in a brief manner, the staggering number of hours spent by members of the Committee in promoting its functions and assignments, are tabulated in the preceding paragraphs under "Activities," "Projects," and the "Statistics for 1965." The time, energy, and devotion expended are purely voluntary and require no financial compensation, except reimbursement for mileage.

Reviewing the statistics for 1965, we may be pleasantly astonished to see a decrease in the number of maternal deaths (42) for this year with an all-time-low maternal death rate (0.22 per 1,000 live births). These figures are considerably lower than those for 1964 (0.28 per 1,000)[2] and for 1963 (0.30 per 1,000).[4] They are even more impressive when we realize that the annual number of live births reported for Ohio has declined every year since 1957! Yet, failing to be lulled into a sense of false security, we feel certain that a certain number of maternal deaths still escape inclusion in our annual report due to various failures in physicians' methods of reporting.

However, adhering to policies and customs followed for the past 15 years, the Committee reviewed every *maternal case* carefully, studying all the facts available, on an *anonymous* basis. As stated above, "Guiding Principles for Obstetric Care"[3] was used as a standard for "Ideal Care" in considering avoidable factors.

Of the 57 cases studied for 1965, 42 (73.7 per cent) were voted *maternal deaths,* while 15 were classified *nonmaternal* deaths (no connection with pregnancy, or the puerperium). Four cases are still pending.

In the age groups designated, most patients were in the 20's (14) and 30's (17). The great majority were multiparae. Nine patients of the 42 died undelivered, of which *one* had a postmortem cesarean

Ohio Maternal Mortality Study
Statistics for 1965

Total Live Births in Ohio, 1965		**194,927**
(Total Cases in files, 11 years, 1955-1965, 1229)		
Total Cases Studied (1965)	57	
Cases not studied due to lack of information	4	
Undetermined	0	
Maternal Deaths (Classified)	42	
Non-White	11	
White	31	
Age:		
Teens	5	
20's	14	
30's	17	
40's	6	
Parity:		
Primigravidae	4	
Multiparae	38	
Unknown	0	
Place of Death:		
Hospital	32	
Home	8	
Other	2	
Type of Delivery:		
Not Recorded	3	
Operative	17	
Nonoperative (spontaneous)	13	
Not delivered	9	
Route of Delivery:		
Not recorded	3	
Vaginal	25	
Cesarean (antemortem)	5	
*(postmortem)	1	
Laparotomy (ectopic preg.)	1	
*Not delivered	8	
Case Classification: (when death occurred)		
Not known	0	
Group I (fr. concept. to 20th wk.)	4	
Group II (fr. 20th wk. to 28th wk.)	1	
Group III (fr. 28th wk. through term)	4	
Group IV (Postabortal, postpartum)	33	
Autopsies: (includes 10 coroners' cases)	32	
Prenatal Care: (apparent from data sheets)		
None	4	
Unknown or not reported	9	
Adequate	16	
Inadequate	8	
Excluded (ectopic preg. and abortion)	5	
Classification of Preventability:		
Nonpreventable	10	
Preventable (avoidable factor)	32	
Patient responsibility (P_1)	10	
Personnel responsibility (P_2)	14	
Both P_1 and P_2	6	
P^3 (Misc.)	2	
Classification of Primary Causes of Death		
Hemorrhage	**16**	
Abortion, without sepsis	2	
Abruptio	1	
Afibrinogenemia	5	
Abruptio	1	
Am. fl. embolus	3	
Dead fetus	0	
(Ruptured uterus	1*)	
Atony, uterine, Postpartum	2	
Ectopic Pregnancy (without sepsis)	2	
Laceration, extrauterine	0	
Placenta Praevia	1	
Retained Placenta	0	
Ruptured uterus (no afibrin.)*	3	
Other	0	
High Risk Related: 6 Non-Related: 3		
Infection	**7**	
Abortion, alleged "criminal"	2	
Abortion, septic, induced	1	
Abortion, septic, spontaneous	2	
Up. Resp. Inf.	0	
Peritonitis	0	
Septicemia (puerperal sepsis)	0	
Septicemia (other)	2	
High Risk Related: 0 Non-Related: 1		
Toxemia	**3**	
Hypertension, chronic (incl. Hypertension with cerebrovascular hem.)	0	
Eclampsia	2	
Hyperemesis Gravidarum	1	
Puerperal Toxemia, Not specified	0	
High Risk Related: 2 Non-Related: 0		
Other	**16**	
Amniotic fl. emb. (no hemorrhage)	1	
Anesthesia	3	
(general)	3	
(regional)	0	
Cardiac Disease	2	
Diabetes	1	
Lower Nephron Nephrosis	2	
Pulmonary Edema	1	
Pulmonary Embolus	5	
Other	1	
High Risk Related: 5 Non-Related: 5		

section. The majority of patients (25) had a vaginal delivery.

Thirty-three patients died postabortal, or postpartum, and autopsies were performed upon 32 of the 42 patients (75.1 per cent). Coroners performed 10 of these procedures.

Of the 42 patients, 16 had adequate prenatal care, while 17 received inadequate care or none at all; the remaining nine were either excluded or not reported. Preventability, with an avoidable factor was voted in 32 of the 42 cases.

A review of the primary causes of death (Fig. 1) reveals some interesting features:

Hemorrhage again leads as a single cause of maternal death, with 16 cases, of which *five* died due to primary afibrinogenemia; there were five cases of ruptured uterus.

Five of the seven patients who died of infection had had a previous abortion (two "criminal," one induced, and two "septic spontaneous").

Only *three* cases had toxemia, as a primary cause of death. Anesthesia (3) was led by pulmonary

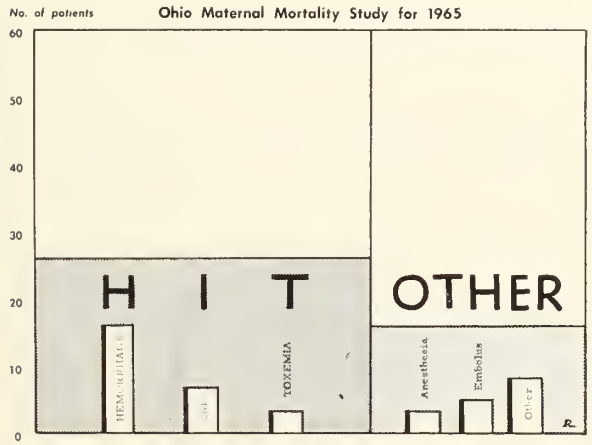


FIG. 1. *Classification of primary causes of deaths, 42 maternal deaths for 1965*

embolus (5) as predominant under "other causes"; there was also one death from amniotic fluid pulmonary embolism.

Among the 42 maternal deaths, 22 patients had (preexisting) "High Risk Factors," of which 13 (59 per cent) were related directly to the ultimate primary cause of death.

Although the number of maternal deaths (42) for the year 1965 is comparatively small, certain trends previously published still prevail, e. g., hemorrhage leads as a single primary cause of death; the great majority of patients died postabortal or postpartum (Group IV); inadequate or no prenatal care was found in the majority of cases reported; approximately three quarters of the cases were voted preventable maternal deaths.

Recommendations

- 1. Once more, the Committee recommends continuation of the Ohio Maternal Mortality Study with its educational facets and ramifications. Only through constant surveillance and evaluation of trends can maternal morbidity and mortality be reduced to an absolute minimum.

- 2. Realizing the dynamic support members of The Council have directed towards the Ohio Study and the Committee's efforts, it is recommended that members focus a stimulus toward local studies within their respective districts.

- 3. Having completed queries and assignments referred to the Committee for investigation and advice, the Committee invites and solicits future problems for solution, concerning maternal health in Ohio.

- 4. Likewise, the Committee solicits recommendations or suggestions from OSMA members, concerning future projects (exhibits, lectures, conferences, etc.) which the committee may pursue. Correspondence may be addressed to: Committee on Maternal Health, Ohio State Medical Association, 17 South High Street, Columbus, Ohio 43215.

With genuine appreciation the Chairman acknowledges the devotion and support of Committee members who completed their duties effectively during the past year or more. For the Committee, the Chairman gratefully acknowledges the assistance extended by The Council, attending physicians, representatives of the many county medical societies, the Ohio Department of Health, Ohio Coroners' Association and numerous other agencies and individuals. Without their continued cooperation and efforts this Maternal Mortality Study could not have been completed.

Respectfully submitted,

ANTHONY RUPPERSBERG, JR. M. D., *Chairman, Committee on Maternal Health*

Approved by The Council of the Ohio State Medical Association.

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NEWS AND Organization Section

Attorney General's Opinion Regarding Withdrawing Blood In Cases Involving Alleged Drunken Driving

OHIO ATTORNEY GENERAL William B. Saxbe has rendered an official opinion that a private physician or registered nurse may legally refuse to draw blood when requested by a police officer in cases involving alleged drunken driving.

In Opinion No. 68-097, in answer to a request from the Holmes County prosecuting attorney, Mr. Saxbe wrote:

* * *

Columbus, Ohio
June 12, 1968

Honorable James H. Estill
Prosecuting Attorney
Holmes County
Millersburg, Ohio

Dear Sir:

Your request for my opinion reads in pertinent part as follows:

"(1) Is the withdrawal of blood for the sole purpose of testing for alcohol content the 'practice of medicine.'

"(2) Can a physician or registered nurse lawfully refuse to administer such a test when a request is legally made at the direction of an officer of law.

"(3) May a physician or registered nurse legally refuse to administer a test when the subject is unconscious or otherwise in a condition rendering him incapable of refusal.

"(4) May a registered nurse or physician require a written consent to be given in their presence prior to the administering of the test.

"(5) Would the physician or registered nurse administering the test suffer civil liability when the same is made at the lawful direction of an officer."

At the outset, it is observed that your questions pertain to the responsibilities and liabilities of physicians and registered nurses with respect to withdrawing blood at the request of a law enforcement official acting under the provisions of Sections 4511.19 and 4511.191, Revised Code. (Implied Consent Law)

Although you are presenting the questions, it would appear that answers to questions one and five would for all practical purposes constitute advice to private physicians and nurses. As you know, the powers and duties of the Attorney General are fixed by statute and as a consequence it would be inappropriate for me to render such advice.

It would appear, however, that question two is germane to the entire problem and that a resolution of this issue will be dispositive of questions three and four, and the opinion will be so confined.

Section 4511.19, Revised Code, reads in pertinent part as follows:

"When a person submits to a blood test at the request of a police officer under section 4511.191 of the Revised Code, only a physician or a registered nurse shall withdraw blood for the purpose of determining the alcoholic content therein. This limitation does not apply to the taking of breath or urine specimens."

I do not construe Section 4511.19, *supra,* to mean that physicians or nurses are legally obligated to withdraw blood upon a request of a police officer. 41 American Jurisprudence, Section 4, Obligation to

Practice or Accept Professional Employment, page 135, reads in pertinent part as follows:

> "In the absence of statute, a physician or surgeon is under no legal obligation to render professional services to everyone who applies to him or seeks to engage him. Physicians are not public servants who are bound to serve all who seek them, as are innkeepers, common carriers, and the like. And the existence of a license law and the possession of a license does not enlarge a physician's duty in regard to accepting an offered patient. An act requiring a license before a person practices medicine is essentially a preventive not a compulsory measure, and one who has secured a license according to statute is under no obligation to take all the cases that offer, and therefore is not liable for damages alleged to result from the refusal to take a case. * * *"

I am unaware of any Ohio statute placing a physician or registered nurse under a legal obligation to withdraw blood under the circumstances being discussed herein.

I am of the opinion that the operation of the Ohio Implied Consent Law as it applies to the withdrawal of blood depends upon the voluntary cooperation of the medical profession.

If individual physicians or nurses do not desire to participate in the program that is their decision to make and it would follow that if there is no legal obligation on the part of private physicians and nurses to withdraw blood, it is within their prerogative to establish limitations for the withdrawing of blood; e.g., that the person be conscious and give written consent in their presence for the withdrawal of the blood.

If, in your geographical area, satisfactory arrangements can not be made for the withdrawing of blood by physicians or registered nurses, there appears to be no alternative but to have law enforcement officials direct that breath or urine tests be given. The two hour limitation for withdrawing of bodily substance, (see Section 4511.191, *supra*) would preclude the use of physicians or nurses residing a great distance from point of arrest. I realize that at times the chemical test may have to be forfeited as to a person who is unconscious or otherwise incapable of taking the breath or urine test.

In conclusion, it is my opinion that a private physician or registered nurse may legally refuse to withdraw blood when requested by a law enforcement official acting under the provisions of Section 4511.191, *supra*.

Respectfully,

WILLIAM B. SAXBE
Attorney General

Physicians Are Warned to Guard Against Forged Prescriptions

Physicians are strongly advised to take extra precautions and to instruct their staffs in safeguarding prescription blanks, in the following warning issued by the Ohio State Board of Pharmacy.

FORGED PRESCRIPTIONS

"Ohio pharmacists have been receiving an increasing number of forged prescriptions for narcotics and other drugs subject to abuse.

"Most of the prescription blanks have been stolen from physicians' offices and hospitals and Pharmacy Board investigators are discovering them to be easily available to the public in some of these places.

"Recent increased activity by municipal, state, and federal law enforcement agencies in the area of drug control has curtailed much of the illicit drug traffic leading to this current trend of addicts writing their own prescriptions.

"The State Board of Pharmacy requests physicians to caution and instruct their office staffs on providing security and control of prescription blanks."

Frank E. Kunkel, Executive Secretary
Ohio State Board of Pharmacy

Tobacco Companies Again Support AMA Research Projects

One of medical science's most intensive investigations gained additional scope recently with pledges by six tobacco companies of an additional $8 million for the American Medical Association Education and Research Foundation's inquiry into the relationship of smoking and health.

The new pledges assure support of the research program through 1973. All of the funds will be allocated by the Foundation to independent scientists conducting research in their own laboratories.

Costs of administering the grants are paid by the American Medical Association and not from contributions.

The program began in June, 1964, shortly after the *Surgeon General's Report on Smoking and Health* was issued and the then-Surgeon General, Luther Terry, M. D., called for further research into the problem. Financial support came from the nation's physicians and an initial $10 million grant from the same tobacco companies.

Since then, 104 investigators or teams of investigators have been at work on the problem in 50 institutions in the United States and five foreign countries.

Governmental Medical Care Programs And Policies of the OSMA

OF PRIME INTEREST to the medical profession is the increasing number of governmental medical care programs and the impact of these programs on the private practice of medicine. In order to better inform the profession on the various programs involved, a special panel discussion entitled "Government Medical Care Programs and OSMA Policies" was held as part of the OSMA Annual Meeting agenda in Cincinnati, May 13-17. Moderator of the panel was Dr. H. William Porterfield, Columbus, chairman of the OSMA Committee on Government Medical Care Programs.

The text of one presentation was previously published—that of Dr. Robert E. Tschantz, Canton, on the topic, "Private Practice in the Future." Refer to June issue of *The Journal,* pages 720-724.

Following are additional papers presented as part of this panel discussion.

Medicine and Federal Legislation

By WILLIAM DORNER, Jr., Akron
Member of the OSMA Subcommittee on Title 19

With the great amount of discussion in Washington and everywhere regarding the Vietnam situation and emphasis on the reduction in spending playing an important role as a prerequisite to a tax increase, one would be led to believe that little time is being spent in discussion and legislation at the federal level on medical programs, but this just is not the case.

Early in March the President's "Health in America" message was submitted to Congress. The President called for:

1. A sharp reduction in infant mortality with increased appropriations for maternal and child care programs and establishment of a new center for population and human reproduction studies and increased funds for birth control programs.

2. Programs to relieve the shortage of physicians and other health personnel by extension and expansion of existing acts.

3. Control of the cost of medical care and better use of present health resources through the development of incentives to reduce health care costs and for a testing of incentive plans to control hospital costs and charges and the establishment of a reasonable cost range for drugs in federally supported programs, and a drug compendium to be prepared by HEW.

4. Reduction of accidental deaths was another point, and the Secretaries of Transportaion, HEW and Defense were directed to assist states and communities in the development of appropriate emergency and rescue plans.

5. The launching of a nationwide volunteer effort to improve the health of all Americans by establishing a President's Council on Physical Fitness and Sports, and in closing his message, the President called upon state and local governments and private enterprise to undertake an extensive 12 point voluntary program to build "a healthier America."

Implementation of his recommendations is under way. The next day the **Health Manpower Act of 1968** (H. R. 15757; S. 3095) was introduced. This act would extend the Health Professions Educational Assistance Act for four years and would provide for grants for the construction of facilities, education and improvement, and student assistance. The AMA has subsequently had the opportunity to testify in favor of this portion of the Act before the Subcommittee on Health of the Senate Labor and Public Welfare Committee. AMA testimony pointed out that there is pressing concern for the need for more practicing physicians. AMA and Association of American Medical Colleges' policy is that all medical schools should accept as a goal the expansion of their collective enrollments to a level that will permit all qualified applicants to be admitted. The **Health Manpower Act** of 1968 would also extend four years; The Nurse Training Act; The Allied Health Professions Personnel Training Act; The Graduate Public Health Training Act; and the Health Research Facilities Construction Act.

Other implementing bills have been introduced. **Regional Medical Programs** (H. R. 15758) — Heart, Cancer, Stroke — extends for five years the programs, but does not provide for construction funds. It also extends for two years the programs of grants for health clinics for migrant workers and includes a provision which would authorize the treatment of alcoholic and narcotic addicts under the Community Mental Health Centers Act. (The Senate companion bill S. 3090 contains only the provisions relating to regional medical programs.)

AMA witnesses have appeared before the Subcommittee on Public Health and Welfare of the House Interstate and Foreign Commerce Committee. A three-year rather than five-year extension was suggested since it is still relatively untried and would give Congress a earlier opportunity to examine its progress. Other witnesses were Dr. Philip Lee of HEW and Dr. Michael DeBakey, who favored the extension of the program, and Dr. DeBakey and Dr. Sidney Farber from Harvard urged construction funds to be authorized.

U. S. Compendium of Drugs (H. R. 15759) calls for a drug compendium to be formulated by the Department of HEW and distributed to physicians, hospitals, and others who have use for such information.

Health Personnel Act of 1968 (H. R. 15760; S. 3096) authorizes a new federal health personnel system which would be known as the Health Service of the United States and administered by the Secretary of HEW. Present commissioned officers of U. S. Public Health Service would be given the option to transfer into this new health service as the PHS is phased out.

HEW is being reorganized, and Philip R. Lee, M. D., Assistant Secretary of HEW, Health and Scientific Affairs will have direct authority of the three branches developing—NIH, Health Services and Mental Health Administration, and the Food and Drug Administration. NIH will continue with its research functions and also have medical education programs of the Bureau of Health Manpower. The new Health Services and Mental Health Administration takes over the rest of PHS functions, including the National Institute of Mental Health, Regional Medical Programs, the Bureau of Health Services, the Bureau of Disease Prevention and Environmental Control, and the National Center for Health Statistics.

The reshuffling at HEW is not over. Dr. Lee was directed to complete department studies on the relationship of HEW health programs to those of other federal departments and agencies such as Medicare, run by Social Security, Medicaid, run by the Welfare Administration, and the health programs of the Office of Economic Opportunity, such as the neighborhood health clinics and Project Head Start.

Christian Barnard, M. D. delivered refreshing testimony to the Senate Subcommittee on Government Research during its hearings on a bill (S. J. Res.145) which would establish a 15-man Commission on Health, Science, and Society to undertake a comprehensive investigation on the legal, social, and economical implications of medical research, including among other things, medical transplants.

Dr. Barnard expressed strong opposition to any outside commission or committee to make the decision for doctors in difficult cases. He stated, "Such a commission would be an insult to your doctors. Doctors have the experience to make such decisions, and they have been making them for very many years. Commissions have been set up in the past to decide on medical progress, and they have in every instance hampered progress." He was joined in his opposition by Professor Emeritus Owen H. Wangensteen of the University of Minnesota. Henry K. Beecher, M. D., Anesthesia Chief of Massachusetts General Hospital of Boston, Adrian Kantrowitz, M. D. of Brooklyn, and John Najarian, M. D., University of Minnesota Surgical Chief testified to the merits of the Commission.

Social Security Administration has begun to distribute the guidelines for experiments in incentive reimbursement for hospitals and physicians under Medicare and other federal health programs. They have asked for participation in the reimbursement experiments by hospitals, physicians, Blue Cross, Blue Shield, group practice prepayment plans, labor-management plans, union clinics, and private health insurance organizations.

On April 22 **The Child Health Act of 1968** (H. R. 16616; S. 3323) was introduced. The proposal contains three major provisions:

First—Under the Maternal and Child Health Care Act it calls for supplemental maternal and child welfare programs to feature comprehensive maternity prenatal and postnatal care for mothers of low income families, comprehensive health care for children during their first year of life, and family planning service.

Second—Establishment of a program for determining federal payments for drugs under Medicare, Medicaid, and Maternal and Child Health Care Act programs.

Third—Major provision gives the Secretary of HEW authority to put into effect any method of payment for health services which is developed by the "incentive reimbursement experiment." If adopted, this provision would give the Secretary of HEW the authority, without further Congressional approval, of determining the method by which providers of care would be compensated for care they rendered under federally assisted programs. Fortunately, Senator Long believes this matter might

well involve asking Congress to sign a blank check, therefore, this portion of the act does not have much chance of passage.

However, this bill completed the introduction to Congress of the major requests of the President's health message of early March.

The lawmakers have indicated that there would be at least four separate investigations of rising health costs. Senator Ribicoff's (D-Conn.) Subcommittee on Executive Reorganization of Government Operations Committee began public hearings on April 22 on problems of health care costs and delivery. It also intends to assess the massive federal investment of $15 billion (fiscal '68) provided to 14 federal departments and agencies for health care activities.

There was considerable testimony regarding national compulsory health insurance. A chief proponent was Governor Nelson Rockefeller, whose proposal included the government paying all or part of the premium for people not able to afford the cost. Controlling hospital costs was also part of his proposal. Economist Victor Fuchs joined Rockefeller in proposing a subsidized national health insurance program. He conceded that "compulsion is not a method to be adopted lightly," but said that the benefits of the plan outweigh the disadvantages.

Wilbur Cohen admitted that he strongly favored universal health insurance as advocated in the 1940's, but the experience of the last two years has shown him that this would be a much more monumental task than was first apparent, and he did not believe that such a plan would at this time be workable and usable. He favored the approach meeting priority needs. The committee also heard considerable testimony encouraging group practice, community health planning, and hospital modernization.

Senator Edward Kennedy (D-Mass.) has submitted two bills. One establishes a joint Congressional committee on health affairs composed of 12 senators and representatives who would study existing legislation and its implications and make recommendations to other Congressional committees on the cost of programs and whether they provide services commensurate with their costs. The other bill would establish a three-man National Advisory Council on Health Policy within the office of the President to set national health goals.

They are busy with health programs in Washington, and most of the programs will have a direct or indirect effect upon you and your practice. Keep abreast by reading OSMA mailings and the short summary of Washington's Week in the *AMA News*.

Heart Disease, Cancer, and Stroke Programs

By CHESTER H. ALLEN, M.D., Portsmouth

Chairman, OSMA Subcommittee on Heart, Cancer, and Stroke

Public Law 89-239, commonly called Heart, Cancer, and Stroke Legislation, was passed by Congress in October 1965 and the concept of Regional Medical Programs was established and developed to implement this legislation. There have been several estimates, most of them variously well informed, as to the numbers of cases involved in the country in these diseases, but the three specific disease conditions mentioned have a wide popular appeal and they are also responsible for the majority of the causes of death and a high percentage of morbidity among our population.

The philosophic concept is perhaps laudable that proposes that through a "wedding" of Federal Funds, Federal Agencies, and knowledgable medical personnel, communications can be increased, knowledge can be disseminated, and forces and material can be marshalled more effectively to find and treat, and bring the benefits of improved and current medical care and knowledge to the patients in these three medical categories; also into the care of related diseases.

This is, of course, but one of the medical programs on the Federal level, and one hopes that the practicing physicians and teachers are not kept so busy that they have no time to be aware of what is going on at the national level and thus have little opportunity to have knowledge of, and to pick and select what is best for their own particular patients and their own practices, and to have any effective influence upon developments in the field of Medical Legislation and planning, both through the regulatory mechanisms of the Federal agencies and the legislative powers of Congress.

Parenthetically, in the *Wall Street Journal* of May 8, 1968, on the Editorial page, Alan L. Otten, in his Column, "Politics and People," stated that there is a growing feeling among a good sector of the Liberals who are instrumental in planning, that prior philosophy, tending to develop a strong Presidency, or Executive Branch of the Government have been in error and that the use of Federal Funds and Federal Spending alone, is incapable of solving all of the social problems, and they feel, further, that it is necessary to map out a larger role in this field, for

(Continued on Page 1051)



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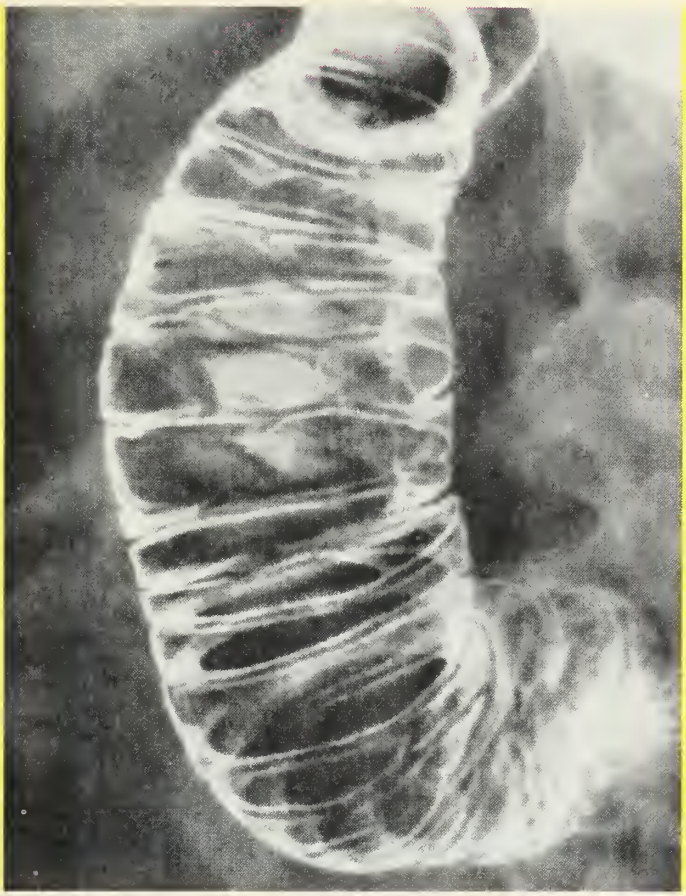
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(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology 89:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique, Lyon chir. 50:445-460 (May-June) 1955.

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(Continued from Page 1046)

Private Enterprise. In the *JAMA* for May 13, 1968, it is also interesting to note that in reporting before Senator Ribicoff's Committee, Mr. Wilbur Cohen alleged that he did not feel that as yet the U. S. would impose a "monolithic" health system on the country, because the country is too large. However, other witnesses, who have supported the views of Mr. Cohen have variously stated that; Hospitals should be regulated as Public Utilities; that Physicians should be phased out as to Private Practice and all should be employed through the Hospitals, on Salaries and under prepayment plans for total medical care.

I would submit that in our own state alone, under such a system, many patients would be rendered a disservice, for they are not reasonably and immediately near a hospital, and many further prefer to go no further for all the services and goods they can obtain, including medical services, than the boundaries of their own Counties. This would negate the claim often made lately that the old County Boundaries are archaic.

The Regional Medical Programs, as to Federal direction, are presently under the direction of Dr. Robert Marston, of the Department of Health, Education, and Welfare (HEW), and there were, as of April 1, 1968, 67 Regional Programs in various stages of development. Of these, one plan is in developmental stage only. Fifty-three plans have been awarded planning grants, and now, 31 months after the passage of the Law, only 13 had been granted Operational Grants. Several plans for operations have been rejected at the Federal level. There are four plans serving Ohio, but there is some confusion as to which counties are served, for in a recent accounting 91 of the 88 counties in Ohio were served by the plans. The programs are centered in Toledo, for the Northwestern Ohio program; Cleveland, for the Northeastern Ohio Program; Columbus, for the Ohio State Regional Program and the Ohio Valley Regional Program, involving Southwestern Ohio, North Central Kentucky and much of Indiana, with headquarters in Lexington, Ky.

There is also the recurring problem of "Town and whether or not this program is truly serving a special purpose as planned, that could not have been served as well specially in Ohio, through the prior developed and currently available Continuing Medical Education Programs. It must be granted however, that many of these present programs are in various stages of development and underdevelopment over the country. There is certainly no lack of programs available over the country however, through other already functioning organizations and agencies for continuing education in the fields of special interest involved in this legislation.

There is also the recurring problem of "Town and Gown," be it valid or not, that colors the acceptance by some of the practicing physicians, since most of the programs are centered through the Medical Schools and larger medical centers. There is no question that all channels of communication should be developed to speed information to the practicing physician. But one must guard against the danger that, occasionally, through too rapid communication, and in a few instances, the Modality of today may become the cause of increased Morbidity of tomorrow.

If the productivity of the individual physician cannot be increased, then all such programs are of little avail. There is certainly no guarantee that the sole development of Group Practice, which has been the subject of two or three conferences, or the investigations into the costs of medical care, for which some of the funds have been used (with its resultant poor and incomplete reporting in the press and news media) is truly serving the purpose of this legislation for improved communication of and better medical services in the fields of Heart, Cancer, and Stroke and related diseases.

Further, there is developing only now some degree of acceptance of and utilization of the services of the various private volunteer nonprofit agencies and organizations, with their dedicated lay people, into the advisory and organizational structures of the programs, so that with the added hands available, again the productivity of the practicing physician is enhanced.

In summary, in the 30 to 31 months that have ensued since the passage of this legislation, there has been much activity, and undoubtedly some benefits, but these months have been spent largely in organization and development of conceptual philosophy. It is fully realized that we should and must be selective, intelligently, in our acceptance of or rejection of the various programs that are supposed to or might help the practice of medicine, and ultimately the patient, or analysis of and the rejection of those plans that merely waste time and add nothing. We are certainly—as is usually the case in the busy practice of medicine—in a time when we have to run at top speed to fall behind a little more slowly. But I am not certain that the whistle that we have purchased is worth the rather large penny that has been spent on it. Since communication and information is an important part of this program, as well as keeping current on this and other activities, I would recommend that the members of the Ohio State Medical Association inform themselves through the pages of the *Ohio State Medical Journal* and appropriate pages *of the JAMA* and the *OSMAgram* and other mailings of what is going on at the Federal level. Also that they inform the Headquarters offices in Columbus of what is going on or planned, or what has occurred that may either help or hinder them. This should be done so that members may be ready and informed as to what will affect their practices; also to have a central agency of information in the state so that the OSMA may even better serve you, the practicing physician. *(Another article on next page)*

Medicare and Freedom

By CARL G. MADSEN, Jr., M.D., Painesville

Chairman of the OSMA Subcommittee on Title 18

"Title 18," Medicare, the particular concern of the Subcommittee of which I have been the appointed chairman these two years past, is a part of the "Social Security Amendments of 1965, "Public Law 89-97. Your attention is called to "Part B—Supplemental Medical Insurance Benefits for the Aged," the part concerned with the practicing physician.

Section 1832 (a) states: "The benefits provided to an individual by the insurance program established by this part shall consist of—(1) entitlement to have payment made to him or on his behalf . . ." (emphasis mine). In these scant words lie the salvation of private practice. The protection of citizenry, physicians and patients alike, from the destructive intrusion of federally appointed "third parties" into the system of delivery of health care to individuals in the age group 65 and older, lies here.

Subsequent interpretations of these words have given special meanings to the terms "assignment" and "option." Grudging social planners encourage the impression that physicians have achieved success in preserving the physician's "option" to bill patients directly, the old fashioned way, on a fee for service basis. It is a subtle but crucial premise contained in this notion of "option" that we, as good citizens, ethically practicing physicians and patients free to choose, must not allow to go unchallenged.

Option, nothing! The prerogative to declare that our contract shall be with our patient is our guaranteed, constitutional right, not simply some "option" magnanimously conferred by some executive appointee writing permissive rules and regulations for the administration of the law. We are not to be required to waive our right freely to choose our partners to contractual agreements nor to confer that choice upon the next person who seeks medical attention, as we are encouraged to do when we are encouraged to send our bill to someone other than the patient—the "assignment."

In this season of refreshing attention to "human rights," it would be dangerously misleading to believe that the cause of "human rights" could be advanced by an apologetic attitude toward men's "property rights." "Property rights" do not describe my relationship to some object I may say I "own" so much as my relationship to my fellow man, the same province to which proponents of "human rights" address their concern.

This pen is my property. That is because all of you have agreed to waive claim to it, leaving the last word in disposition of the pen to me. Since I have disposition of this pen only at your sufferance, properly speaking, it is your place, not my own, to assert that this pen is my property.

But, it would be cumbersome to have to seek your leave regarding every item. What we all do instead is to agree that if I have acquired an item through certain agreed upon practices, your claims will be automically vacated and your sufferance automatically conferred. This is to say that I can have any property that I can acquire by these standard practices.

It turns out, then, that what I assert when I assert that something is my property is that the standard system of agreements among us is intact as to practice governing the acquisition of property. I can assert that as confidently as you. What I assert when I assert that this pen is mine, is that the standard system of agreements prevails intact, permitting me disposition of the pen as if I had entreated your sufferance and as if your sufferance had been conferred.

It follows, if the system of agreements were to be vacated, that I could no longer rest secure in the knowledge that you would leave the disposition of the pen to me, or the disposition of land, or of services, or of any other property. Every acquisition would again be subject to cumbersome, piecemeal dispute. The merit in maintaining our system of agreements intact regarding practices by which disposition of property is assigned, then, can hardly be overestimated. It makes it possible for me to be confident in my assertions regarding what property is at my disposal.

When I was in the Navy I got introduced to new vocabulary. One of the more poignant terms was "cumshaw." Cumshaw is derived from a Chinese word conveying "to tip," as in a restaurant. In the Navy it had come to mean the practice of one government employee swapping goods that were not his for goods that were not the property of another government employee. This way the medical officer got his sick bay painted with government paint and the painter got his drinks laced with government medicinal alcohol.

I entertain the happy delusion that a Naval Medical Officer was responsible for persuading Congress that the practice of cumshaw should not be standard but should be optional in securing medical services for people in the age group 65 and over. Happily, physicians may optionally send their bills to the third

party rather than be required to do so; happily, the standard system of agreements whereby the physician sends his bill directly to the patient as his sole contractual party, with the physician confidently disposing his own services, applies as the generally agreed upon way in which patients may secure medical services. Happily, that system of agreements has not broken down; it remains intact in Title 18.

If the day should come when the physician no longer stands confident in the disposition of his own services, when the system of agreements is no longer intact, then physicians and Title 18 beneficiaries alike will have suffered a severe setback. Cumshaw will have become the rule instead of the option and our services will have been given by some third party to the ill as a sort of "tip." We should refuse to accept that our professional services be rated as a gratuity to be passed from the hand of one government employee to the hand of another, neither of whom has acquired the right of disposition by adherence to standard practices. We should strive to keep as standard the system of agreements whereby you and I confidently retain the last word in the disposition of our services along with other properties which each of us has acquired by adherence to standard practices. Happily, in writing Title 18, Congress has concurred.

We must be watchful that Congressional concurrence and concern does not flag in the confusing years ahead. In authorizing experiments in the delivery of health care under Section 402 of the Social Security Amendments of 1967, Public Law 90-248, Congress must be warned that its responsibility has only just begun and that it must be watchful regarding executive adherence to these same agreements. The same goes for Section 237 in which Congress has given the Secretary of Health, Education, and Welfare unlimited latitude in the shaping of rules and regulations which the Secretary may impose in the name of ". . . efficiency, economy, and quality of care."

Organized medicine must continue to insist upon direct billing of patients as the standard, prevailing practice, as the physician's right, not as an "option" subserviently accepted. It is only by continuing to bill our patients directly that we can continue to be our own men and our own patients can continue to handle their own affairs. As citizens, as physicians, and as patients, we can do no better!

Title 19 — Public Welfare Medical Assistance Program

By PAUL A. JONES, M. D., Zanesville

Chairman of the OSMA Subcommittee on Aid for the Aged, Blind, Dependent Children, Disabled, and Title 19

Title 19 (Medical Assistance Program) has become a reality under the Social Security Act, Amendments of 1965. This subcommittee has had several meetings during the past two years. On at least three occasions the committee has met with representatives of Ohio Department of Public Welfare. From these meetings there has arisen certain discussions which may be helpful in establishing firm policies for future developments.

It is well to remember here that the governmental planners are full time. Some appear to have a socialistic and/or communistic basis for their dedication. Your committee works as a part time investigator of Title 19 and it requests that you as individuals relay to us through the state office of the medical association your impressions and your recommendations.

As Title 19 programs encompass the Aid for the Aged, Aid for the Blind, Aid for the Disabled, and Aid for Dependent Children, approximately 3 per cent of the total population of Ohio will be covered. In some of the other states from 5 to 10 per cent of the population are involved. In this regard Ohio is in a better position than many of the other states. To be sure, in certain areas of our state this percentage will be higher. Wilbur Cohen estimates nationwide 35 to 40 million people are deserving of medical assistance. This estimate may be as inaccurate as some of his other predictions.

It is apropos to turn now to two states that jumped early into Title 19 programs. As many of you may know, the physician and his societies are or will be called upon to make the Medical Assistance Programs under Title 19 work. California Health and Welfare Department has already asked California physicians to make adjustments in their charges (downward, of course). Officials in California state that over-utilization was not a factor in the economy cutback, but the per case rate was too "rich" a mixture. They are asking less utilization to keep the program within

sensible financial bounds. Thus the responsibility for rescuing the program is placed squarely on California physicians. This may well be the case in Ohio.

In California the Public Health Committee of the State's Assembly has suggested that if the Permanente Group can furnish cheaper medical care for Title 19 recipients, then it should furnish the care. The free choice of physician is obviously abandoned if this should become a reality.

Governor Nelson Rockefeller, testifying before Senator Ribicoff's committee stated that medical care paid from tax revenues, such as the Title 19 program, had serious shortcomings. He recommended a system of health insurance paid all or in part by government. He stated this would be cheaper than medicaid which "contains no self-restraining to curb abuse and excessive expansion." "Medicaid beneficiaries do not contribute financially and have no personal stake in the fiscal health of the system."

At the same time Mr. Cohen stated to the same committee "Quality of care has been improving, but there are great deficiencies in this country's health care system. The infant mortality rate is a scandalous comment on the availablity of health care."

Before the same committee, another pawn of HEW, Phillip Lee, M. D. stated that he could not name a single community in the United States that offered outstanding care to all residents. By the same token, he offered no proof of this statement, nor did he make any comments relative to medicine elsewhere.

Medicaid is running costwise far above the original estimates. In 1968 the Federal costs are at least 25 per cent higher than expected. In Ohio the problems between the physician and the Welfare Department in regards to finances probably are only beginning. During meetings with members of the welfare department certain regulations purportedly blocking separate billing by HEW were quoted, but as yet have not been produced.

The political scientists Herman and Ann Somers recently appointed to posts in HEW have said in discussing physician fees, "The inescapable question is being raised as to whether it is feasible for the government to guarantee to any group or profession payment at any level the group may unilaterally elect. **The Entire Fee for Service system is being called into doubt.** The present arrangements are so vulnerable it seems unlikely that they can be lived with very long." This to a large degree outlines the attitude of some of the officials dealing with Title 19 both at a state and national level.

As Title 19 is scrutinized in detail, it is of interest to note the make-up of the State Medical Advisory Committee as appointed by the Governor with certain ground rules suggested by HEW. The committee consists of 13 members—three are M. D.'s, but only one a practicing physician. This seems to be the weapon of the bureaucrats—namely the inclusion of a title that sounds authoritative, but in reality and fact makes meaningful suggestions by the medical profession virtually weightless. There is a strong question in the minds of many whether the Medical Advisory Committee as constituted has met regularly enough, has had satisfactory enough attendance, or has had a meaningful agenda.

In a personal meeting with Mr. Zuber, the chief in charge of Ohio Title 19, the speaker was advised of some problems confronting the Department of Public Welfare in regards to Title 19. In general, these problems had to do with billing practices.

1. Under group practice, the department has received statements from various groups with no physicians' names submitted. In others a list of names were included but no reference as to who rendered the service was made. In another instance, a clinic sent in a statement and upon investigation the statement came from a chiropractor.

2. The department has difficulty in billing resulting from resident staff and teaching staff-patient relationship.

3. Some hospital outpatient departments cause the department problems in the question of services rendered.

4. There exists the problem of double billing as it applies to some hospital based specialists.

The Ohio Department of Public Welfare realizes that the term quality medical care has been loosely used. No definition either at a state or national level exists for this frequently used term.

Mr. Zuber stated that the regulation on elective and nonemergency surgery as outlined on page 3 of the March 1968 *Handbook for Professionals* was indefinitely deferred.

The *Handbook for Professionals* has been a request by the Committee on Government Medical Care Programs. This is an example of cooperation with your committee by the ODPW.

To summarize, I wish to state:

1. In Ohio the dialogue between this committee and the Department of Public Welfare is continuing.

2. This committee needs your help in problems arising that affect Title 19 recipients.

3. All must be ever vigilant that the private sector of medicine will be heard through this and other government medical care committees.

OSMA Scholarships Awarded . . .

Two Students Entering Medical School Selected by Committee; Eight Students Now Aided by OSMA

THE AWARDING of medical scholarships of $2,000 each, to Rebecca L. Terrell, New Vienna, Ohio, and to Larry R. Thomas, Rt. 2, Findlay, Ohio, was announced by the Ohio State Medical Association.

Dr. Theodore L. Light, Dayton, the Association's President, said this year marked the 20th annual awarding of the Association's medical scholarships.

Miss Terrell, 21, completed her premedical studies this year at Ohio University, Athens, and will enter the College of Medicine of the Ohio State University this September.

Mr. Thomas, 22, will enter the Ohio State University College of Medicine this fall, having satisfactorily completed his premedical courses at OSU.

The two winning applicants were selected in competition judged on the basis of character, integrity, intelligence, mature personality, interest in community life, leadership and scholastic ability.

The scholarship winners will receive $500 for each year of their medical studies. Dr. Light stated that this September there will be eight students in medical college who have received awards from the Ohio State Medical Association.

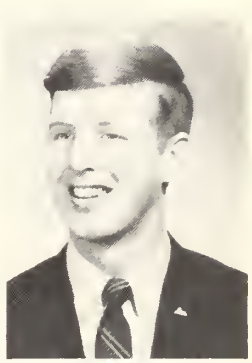
Other students on OSMA Scholarships include William J. Brown of Greenville, a senior in the University of Cincinnati College of Medicine; George C. Myers of Logan, a senior in the Ohio State University College of Medicine; Harold L. Mast of Wooster, a junior at OSU; Lawson C. Smart of Youngstown, a junior at the University of Pittsburgh; William H. Kose of Pickerington, a sophomore at OSU, and Alan T. Tong of McComb, also a sophomore at OSU.

Dr. Light pointed out that the scholarships are a part of the Association's continuous activities to stimulate young men and women of Ohio in becoming Doctors of Medicine, with emphasis on their becoming family physicians serving nonmetropolitan communities.

Larry Thomas maintained an outstanding scholastic record throughout his school training. He ranked highest in his high school class of 50 students and was president of his junior and senior classes. For six years he played with marching bands—the All Ohio Boys Band and the Ohio State Future Farmers of America Band. He participated in class plays, received several honors including gold rating in FFA public speaking; belonged to the parliamentary procedure team; and participated in the FFA State Fair demonstration team which won gold ratings.



Rebecca Terrell



Larry Thomas

Larry attained many honors during his college career. He held top posts in the public relations field, in his dormitory organization, was on the planning board for Homecoming ceremonies, was on his college council and the senior class committee, and he was named outstanding senior man in the 1968 college class. Virtually all of his college expenses came from his own earnings.

Miss Terrell is another student with an outstanding record. Reared on a farm, part of her philosophy is expressed in the following excerpt from a narrative written with her application:

"It is not a blind wish to return to the environment of my childhood. To be sure, rural life is not completely idyllic—school systems may need advancement, health facilities may be less than those in large population centers, ignorance, narrow-mindedness, and poverty exist as they do everywhere in the world. But against all such problems weighs the richness of rural life. Even the towns and villages with sources of income other than directly from agriculture have their roots deep within rural soil. This is their strength for it maintains the awareness and appreciation of ife processes in nature and in man. Thus the communities' outlooks and attitudes demand reflection and the assurance that changes will mean true progress or growth because the people know that both are essential to life.

"And in what better atmosphere could one hope to practice the art of healing? - - - "

Outstanding Scientific Exhibits At OSMA Annual Meeting

SCIENTIFIC EXHIBITS provided important features of the 1968 OSMA Annual Meeting in Cincinnati, May 13-17. Out of some 40 Scientific Exhibits, a judging team selected several as outstanding. This procedure was in keeping with recommendations of the Committee on Scientific Work approved by The Council. The authorized award in each case consists of a certificate of recognition, a permanent type plaque, and, in the case of gold, silver, and bronze awards in the two fields of original investigation and teaching, monetary gifts. A summary of exhibits selected to receive recognition was printed in the July issue of *The Journal.* Following are brief descriptions of some of the award winners. Additional summaries will be published in subsequent issues.

* * *

Exhibit on CWRU Perinatal Unit Is Gold Award Winner

The exhibit entitled "A Perinatal Unit—A New Concept in Maternal and Infant Care" was the Gold Award winner in the field of Original Investigation.

The Perinatal Unit of Case Western Reserve University is located at Cleveland Metropolitan General Hospital, and is supported by a Grant of the National Institute of Health. The Unit has been especially designed for the clinical investigation of pregnant women and their fetuses. There are three labor rooms, two core laboratories completely equipped for chemical and biochemical investigation, a room with electronic monitoring equipment, a delivery room, and a nursery.

All the labor rooms, core laboratories, delivery room, and the nursery are interconnected electronically by television and an intercom system. The director of the Perinatal Unit and obstetrician in charge is Dr. Jacques F. Roux. The pediatrician in charge is Dr. Avron Sweet. Twelve nurses on the Staff of the hospital are specially trained to give both obstetrical and pediatric care and to aid in the investigations. An executive secretary and one clerk manage the office duties.

A physician desiring to carry out an investigation in the Perinatal Unit must complete a protocol which is then considered by the Committee on Clinical Investigation. If approved, it must then be reviewed by the Committee on Investigation in Humans of Cleveland Metropolitan General Hospital and Case Western Reserve University School of Medicine.

The purpose of the Unit is to encourage and develop investigation in pregnancy and the study of the fetus and newborn. It also offers an opportunity for doctors, residents, students, and nurses, to learn skills in research and acquire knowledge in obstetrics and newborn pediatrics, especially in the management of high risk patients, their fetuses and newborns.

Research Projects

Research studies under way at the present time in the Perinatal Unit and principal investigators are shown in the following summary. Teaching appointments of investigators are with the Case Western Reserve University School of Medicine and hospital appointments are with the Cleveland Metropolitan General Hospital where the programs are conducted.

The Monitoring of Pregnant Women and Their Fetuses in Labor — Maximino Alcancia, M. D., senior instructor in anesthesiology and fellow in anesthesiology; M. Jassani, M. D., instructor in obstetrics and gynecology and research fellow in OB-Gyn.; and Jacques F. Roux, M. D., associate professor of OB-Gyn and director of the Perinatal Research Center.

Recording of Fetal EKG and Monitoring Uterine Contractions by Telemetry — Frank Critchfield, M. D., associate obstetrician; and Michael R. Neuman, Ph. D., associate professor of bioengineering.

Diabetes Mellitus in Pregnant Women and Their Newborns — R. Schwartz, M. D., professor of pediatrics and director of the Department of Pediatrics; Peter Adam, M. D., Research, Department of Pediatrics, and research fellow in metabolism; and Katherine King, M. D., research fellow.

The Use of Oxygen and Bicarbonate in the Prevention of Hyaline Membrane Disease — A. Sweet, M. D., associate professor of pediatrics and director of the Department of Pediatrics.

Progesterone Production in Normal and Abnormal Pregnancy — Brian Little, M. D., professor of obstetrics and gynecology and chief of the OB-Gyn Department; Reinhart Billiar, M. D., instructor in biochemistry and research associate in OB-Gyn; T.

Outstanding Annual Meeting Exhibits



Gold Award
in Original Investigation
"A Perinatal Unit — A New Concept
in Maternal and Infant Care"



Honorable Mention
in Original Investigation
"Physiologic Voiding Test
in Children"



Honorable Mention
in Teaching Field
"Surgical Aspects of Intersex"

J. Lin, M. D., associate professor in OB-Gyn and associate visiting obstetrician and gynecologist; Katherine King, M. D., research fellow; Margaret Knappenberger, B. S., research associate in OB-Gyn; and August Hensons, B. S., research associate in OB-Gyn.

The Role of Tubular Factors in the Response to Saline Loading of Normal and Hypertensive Pregnant Women and Patients with Preeclampsia — M. Lindheimer, M. D., senior instructor in medicine, associated with the Renal Electrolyte Division; and Peter Weston, M. D., assistant professor of OB-Gyn and research fellow in obstetrics and gynecology.

Rosemary Lemr, R. N., head nurse in the Perinatal Clinical Research Center, plays a leading role in the research projects and was one of the sponsors of the OSMA exhibit.

* * *

Honorable Mention Goes to Exhibit On Voiding Test in Children

Honorable Mention in the field of Original Investigation was accorded the exhibit, entitled "Physiologic Voiding Test in Children," sponsored by a team from Akron. The project is associated with Akron Children's Hospital. The following physicians comprised the team: Walter A. Keitzer, M. D., Birendra Tandon, M. D., James Allen, M. D., Edward Bernreuter, M. D., and Mark Herrold, M. D.

The exhibit was a presentation of the urodynamics of voiding as illustrated by specific voiding patterns, and description of a new treatment of recurrent urinary tract infection which utilizes these patterns in the preoperative evaluation and postoperative follow-up.

Illustrations of standard normal and abnormal voiding were viewed by the observer while simultaneously listening to the sounds of voiding. A working Voiding Audiograph machine for conversion of the patterns to graphs was part of the exhibit equipment. Extracts of various published articles relating to the subject were made available for distribution and are still available from the sponsors.

The four recognized types of voiding patterns — normal, compensated, decompensating, and decompensated patterns — were presented. Illustrations also presented preoperative and postoperative cystograns and audiographs of children with lower urinary tract obstructions. Also included were statistics relating to 6,125 cystoscopies in children.

* * *

Exhibit on Aspects of Intersex Given Honorable Mention

The exhibit entitled "Surgical Aspects of Intersex" was given Honorable Mention in the Teaching field by the judging committee. Sponsors were Lester W. Martin, M. D., and William R. Richardson, M. D., Cincinnati Children's Hospital, and Department of Surgery, University of Cincinnati College of Medicine.

The purpose of the exhibit was to outline a practical approach to the diagnosis and management of intersexuality in infancy and childhood, incorporating recent advance in the fields of endocrinology, radiology, and medical cytogenetics.

Sponsors point out that sexual ambiguity in the newborn continues to rank as a real, if sometimes obscure emergency and may prove to be as numerically frequent as cleft lip and palate, polydactylism, hydrocephalus or thyroglossal duct cyst. During the past decade, studies of the sex chromatin pattern and sex chromosome constitution have been of immense help and interest in unraveling the group of anomalies presenting problems of sex determination, but experience has continued to indicate that anatomical features and potential for gonadal growth must take precedence in the important decision of sex assignment.

Topics emphasized and illustrated in the exhibit included:

1. Nomenclature and classification of intersex.
2. Criteria of sex identification and assignment.
3. Roles of special diagnostic techniques.
4. Cases illustrating surgical aspects of diagnosis and management of the types of developmental anomalies encountered in clinical pediatrics.
5. Specific surgical techniques used in laparotomy, gonadal biopsy and reconstruction of external genitalia in infancy.

Cincinnati Medi-Club Sponsors Orient Adventure Tour

Another unique feature has been added to the (Cincinnati area) Medi-Club's 1968 Orient Adventure—a medical seminar.

The club has finalized plans for a medical seminar to be held in Tokyo and Hong Kong during the Orient Adventure, scheduled to depart Cincinnati September 14.

Dr. Wei-Ping Loh, chief pathologist of the Gary Methodist Hospital and associate professor of pathology at Chicago Medical School, is chairman of the program and has arranged a program which will be of interest to most physicians.

Upon completion of the seminar, the participating physicians will receive certificates showing the exact program and the date of participation.

John E. J. McSweeney, M. D., is chairman of the Travel Committee, and the address is 320 Broadway, Cincinnati 45202 (the headquarters office of the Academy of Medicine of Cincinnati).

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Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Are You Eligible to Vote?...

September 25 Is Deadline for Those Who Must Register In Order to Vote in the November 5 General Election

SEPTEMBER 25 is an all-important date for many voters. It is the last day on which voters may register to vote in the November 5 General Election, if they are not already qualified. The following information on registering and voting is taken from a pamphlet issued from the Ohio Secretary of State's office.

Dates to Remember

September 6. Boards of Elections begin mailing Absent Voter Ballots to members of the armed services from whom applications have been received.

Also first day for Boards of Elections to receive applications for Absent Voter Ballots by civilians outside the United States, and to begin mailing Absent Voter Ballots to civilians outside the United States.

September 25. Last day to register.

October 6. First day for Boards of Elections to receive applications for disabled and civilian absent voter ballots for persons located within the United States. Also first day of period during which votes may be cast at Boards of Elections by voters who expect to be absent from their counties and precincts on Election Day.

October 31. Last day (ending at 4 P.M.) for voting at Boards of Elections by voters who will be absent from their counties and precincts on Election Day.

November 1. By 12:00 NOON of this date civilian absent, sick, or disabled voter ballots must be delivered to clerks of Boards of Elections.

November 2. By 12:00 NOON of this date applications for Armed Service Absent Voter Ballots must be received by clerks of Boards of Elections.

November 5. General Election Day. Polls open at 6:30 A.M. and close at 6:30 P.M.

Qualifications for Voting

You are qualified to vote if:

- You are a citizen of the U. S.
- You are at least 21 years of age or will be on the day of the next General Election (November 5, 1968.)
- You have, at the time of the election, been a resident of:

the state for one year;
the county for 40 days;
the voting precinct for 40 days.

(If you have moved from one county to another county within Ohio, or from one precinct to an-





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Fort Washington, Pa.

other in the same county within 40 days before the election, you may vote in the precinct from which you moved.)

• You are registered. (This requirement applies only to persons who reside in registration territory.)

You must be registered to vote if:

You reside in registration territory. (Any city having a population of 16,000 or over, or any area which has adopted registration. Contact your County Board of Elections to determine your registration status.)

Registration in Ohio is permanent, and need not be renewed unless:

• You have not voted at least once in the past two calendar years.

• You moved since you registered.

• You have changed your name. (A woman must re-register if she has married since she registered. If married after September 25, she may vote on November 5, but not thereafter, under her former name.)

Officials to Be Elected

Each person voting in Ohio on November 5, 1968, will receive at least four ballots:

1. Presidential Ballot;
2. Office Type Ballot;
3. Nonpartisan Ballot;
4. Questions and Issues Ballot.

The names of the candidates for President and Vice-President chosen at the national political party conventions will appear on the Presidential ballot.

The following state, district, and county offices will appear on the Office Type Ballot: United States Senator, Representative to Congress, State Senator, State Representative, two County Commissioners, Prosecuting Attorney, Clerk of Courts, Sheriff, County Recorder, County Treasurer, County Engineer, and County Coroner.

The Nonpartisan Ballot, which does not show any political designations, will contain the candidates for: Chief Justice of the Supreme Court; two Judges of the Supreme Court; Judge of the Court of Appeals; and you will vote for Judge of the Court of Common Pleas, and Judge of the County Court in some counties.

Each of the political parties will elect new Central Committees, at both the state and county level, at the Primary Election.

The Questions and Issues Ballot will contain any bond issues, tax levies, and miscellaneous questions and issues submitted in your political subdivision.

OPEN LETTER TO PHYSICIANS OF OSMA...

Regarding Ohio's Part as Host to the October 6-13 Columbus Meeting of the American Association of Medical Assistants

IN THE JANUARY ISSUE of the *OSMA Journal*, I wrote to all of you, requesting your help and assistance in promoting the Ohio State Society of Medical Assistants. I am again asking for your cooperation.

The parent organization of OSSMA — the American Association of Medical Assistants — is holding its Annual Meeting at the Sheraton-Columbus Motor Hotel in downtown Columbus, October 6 to October 13. The Ohio State Chapter, of course, will be the host group and is working diligently to insure a real good program.

The members of OSSMA have been contacted and I am sure they will be in attendance. However, there are thousands of medical assistants in Ohio who are not members — as yet — and it is to these nonmembers that I particularly want "to speak." Our organization is most anxious that nonmembers also attend this Annual Meeting. It will give these girls an insight into the organization — it will enable them to view interesting exhibits — it will expose them to many interesting events and speakers that they would not otherwise have the opportunity of seeing.

The first part of the week is devoted to meetings of the AAMA officers. The House of Delegates will have its first meeting Wednesday morning, October 9, 1968, and that, of course, is an open meeting. The first social event of the meeting will be the Presidential Reception (a get acquainted affair) and will be held Wednesday evening. The House of Delegates again meets Thursday morning, October 10, 1968, and the Exhibit Halls will be officially opened.

The first Educational Session will be held starting at 9:15 A. M. on Friday, October 11, 1968, and the theme of this program will be "Progress Through Professionalism." A Similar program will be held on Saturday. I shall not attempt in the limited space to list the entire program. However, I would like to mention the titles of several of the speeches that will be made:

1. "Pursuit of Excellence" by Dr. Russell Fisher of Baltimore, Maryland.
2. "A Legislator's Look in the Medicine Cabinet" by Honorable John M. Ashbrook, who is the Ohio Representative to the Congress of the United States.
3. "Open Heart Surgery" by Dr. Howard Sirak, of Columbus.
4. "Exchange Transfusions"
5. "The Art of Patient Relations" by Dr. Eugene Capocasale, from Zanesville, Ohio.
6. "The Important Middle Link — You!" by Dr. Robert Atkinson, of Columbus, Ohio.

A luncheon will be held Friday noon. Dr. Dwight Wilbur, President of the American Medical Association, will preside.

The educational part of the program will be in-

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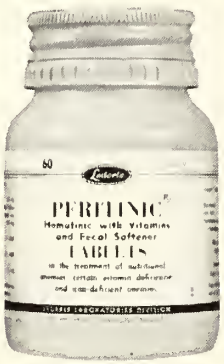
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terrupted by a "Roaring 20's Party" at 7:00 P. M., and I am sure this will be enjoyable to all participants.

The educational part of the program will continue on Saturday, October 12, and the following subjects will be discussed:

1. "Quackery in the Health Field."

2. A Panel will discuss the "Cost of Medical Care."

3. "To Move or Not to Move — That is the Question." This is obviously regarding parliamentary procedure.

4. "To Advise and Counsel — That is Their Function."

5. "To Reflect Your Best Image — That is the Purpose."

6. "To Write It Right — That is the Idea!"

Again the educational part of the program will be interrupted by a Cocktail Reception and an Inaugural Banquet. In my opinion, this will be the highlight of the entire program since the Honorable Tennyson Guyer, Ohio State Senator, will be the Master of Ceremonies. From my previous experience, I am sure he will make comments that will be long remembered by your assistants.

There will then be a parade of the State Presidents and a lot of fanfare which will be most enjoyable such as the installation of the Officers, the presentation of the Gavel, the presentation of the Past President's Pin, etc.

The new President of AAMA, Mildred Crawford, will then make her acceptance address and there will be a reception for New Officers.

The meeting will conclude on Sunday, October 13, 1968, with a Board of Trustees meeting.

I am sure this will be a meeting that will long be remembered by all those in attendance. The members of OSSMA will be in attendance. I am particularly asking that you physicians whose assistants do not belong to this group make a special effort to have your girls attend. This is a session that they will never forget.

For additional information, write to Jean MacCall, AAMA Convention registrar, 139 E. Lakeview Ave., Columbus, Ohio 43202.

Richard L. Fulton, M. D.
Advisor, OSSMA.

Dr. Harold L. Keiser, Fremont physician, has accepted an appointment with the U. S. Department of Health, Education, and Welfare as consultant to the Office of Marketed Drugs in the Bureau of Medicine, Food and Drug Administration.



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☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

Woman's Auxiliary Highlights...

By MRS. ROBERT E. PUMPHREY, Chairman, Publicity Committee

3055 Big Hill Road, Dayton 45419

REGIONAL FALL CONFERENCES of the Woman's Auxiliary to the OSMA: Doctors' wives needed and urged to attend — two all-day meetings scheduled:

Southern Ohio Region — Districts 1, 2, 7, 8, 9, and 10 — Tuesday, October 8, Washington Court House Methodist Church;

Northern Ohio Region — Districts 3, 4, 5, 6, and 11 — Wednesday, October 9, Marion Country Club.

"Sunrise, Sunset, Sunrise, Sunset" — swiftly went the days. Another summer has set on the world horizon and another fall is here, bringing with it stimulating goals and new ideas — among them the Auxiliary's new plan to hold northern and southern Ohio one-day regional conferences that will, in the words of WA-OSMA president, Mrs. Malachi Sloan, "bring the conference closer to your home and capsule it into one inspirational day."

1968 Fall Conference

Monday, October 7 — State Board Meeting, 10:00 A. M., Central Office, 4075 North High Street, Columbus.

Tuesday, October 8 — Southern Region, Districts 1, 2, 7, 8, 9, 10, at Washington Court House Methodist Church.

Wednesday, October 9, Northern Region, Districts 3, 4, 5, 6, 11, at Marion Country Club.

(Special Note: If counties should have a preference as to the day or place, they have the privilege of making their own choice.)

9:00 - 9:45 A. M. — Coffee and Registration — County presidents and presidents-elect, county chairmen, others.

9:50 - 10:20 A. M.—Getting acquainted with "Program Magic" — for the Auxiliary; for the Community.

(Programs can have a glamour all their own via the special make-up of Action and Approach.) Mrs. Malachi W. Sloan, President; Mrs. S. L. Meltzer, President-elect.

10:25 - 10:55 A. M. — Two Concurrent Workshops.

"Round Table" discussion designated for each session. There will be five minutes briefing by chairman, with 25 minutes for audience participation, questions and answers (moderated, of course, by chairman). This will hold for most sessions.

Group A — Community Health Service — Mrs. Elden C. Weckesser.

Group B — Mental Health — Mrs. Daniel S. Wolff.

11:00 - 11:30 A. M. — Three Concurrent Workshops.

Group A — Membership — Mrs. Carl F. Goll, 1st vice-president; "Every member counts" — Panel — District Directors, Mrs. R. H. Williamson, members-at-large.

Group B — Health Careers—Mrs. A. J. Zito.

Group C — Program Coordination and Promotion — Mrs. S. L. Meltzer; Mrs. J. Kenneth Potter, 2nd vice-president.

11:35 — 12:00 NOON — Two Concurrent Sessions — Our Image (12 minutes each — groups remain in places, leaders move.)

Group A — Medical Auxiliary News — Mrs. H. W. Allison.

Group B — Publicity—Mrs. Robert E. Pumphrey.

12:05 - 12:30 P. M. — Social Hour — Exhibits — Historian's "Corner."

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President: Mrs. Malachi W. Sloan, II
415 Towerview Rd., Dayton 45429

President-Elect: Mrs. S. L. Meltzer
2442 Dorman Dr., Portsmouth 45662

First Vice-President: Mrs. Carl F. Goll
1001 Granard Parkway, Steubenville 43952

Recording Secretary: Mrs. C. L. Johnson
660 N. Detroit St., Kenton 43326

Second Vice-President: Mrs. J. Kenneth Potter
3113 Eastwick Dr., Cleveland 44118

Corresponding Secretary: Mrs. Roy Rounds
71 Greenhill Rd., Dayton 45405

Third Vice-President: Mrs. Harry L. Fry
810 Matson Pl., Apt. 703
Cincinnati 45204

Past President and Nominating Chairman:
Mrs. J. Paul Sauvageot
2443 Ridgewood Rd., Akron 44313

Treasurer: Mrs. Russell L. Wiessinger
2280 West Wayne St., Lima 45805

12:30 - 1:15 P. M. — Luncheon — Mrs. Malachi W. Sloan presiding.

1:15 - 2:00 P. M. — Luncheon Program on Legislation; Guest Speakers: Lee Ann Elliott, AMPAC; Dr. William Lewis, vice-chairman, OMPAC; Hart F. Page, Executive Secretary OSMA; 10 min. question and answer period; Introductions, Mrs. Harry L. Fry.

2:15 - 2:45 P. M. — Two Concurrent Sessions.

Group A — AMA-ERF — Mrs. A. G. Steele; Mrs. Jack Weiland.

Group B — International Health — Mrs. Max Schnitker; Mrs. E. L. Jung.

2:50 - 3:10 P. M. — Two 20-Minute Workshops — Concurrent.

Group A — Safety — Mrs. Karl Ulicny.

Group B — The News on Dues — Mrs. Russell Wiessinger, treasurer.

3:15 - 3:40 P. M. — What Do You Think? Group Participation — Mrs. S. L. Meltzer and chairmen.

Fall Conference Chairmen: Washington Court House — President and chairman, Mrs. Marvin Roszman; Cochairman — Mrs. James Rose; Advisor — Mrs. N. M. Reiff.

Marion Conference — President, Mrs. Albert May; Chairman, Mrs. William Leffler; Cochairman, Mrs. Burt Altmaier.

The conferences will be motivated by an all out effort to acquaint every doctor's wife with our program. Our officers and chairmen will constitute a travel team. We hope to meet each and every one of them either on October 8 in Washington Courthouse or October 9 in Marion. The same program and the same speakers will be presented in both north and south regions. Emphasis will truly be on getting to know YOU, so that together we can move forward. Mrs. Samuel L. Meltzer, president-elect, is responsible for the planning of the programs for each day.

Letter from Membership-at-Large Chairman

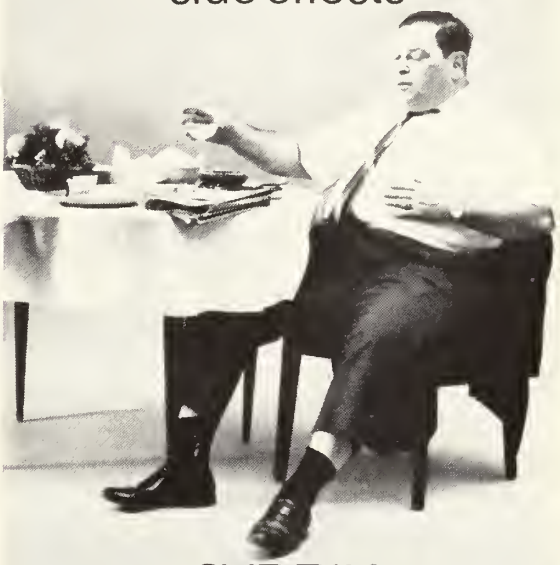
410 Wasta Avenue
Huron, Ohio 44839
August 1, 1968

Dear M. D.'s Wife:

This is an open letter to all doctors' wives who are not affiliated with the Woman's Auxiliary to the Ohio State Medical Association. The members of the Auxiliary would like to know YOU!

As doctors' wives, we all have unique common interests. We would like to share this interest with you — our hopes and plans — yes, even our problems — as we work together to promote better health and good public relations in the field of medicine. There-

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fore, a warm personal invitation is extended to you, to meet with us at Fall Conference.

Two meetings are being planned in October in an effort to make the conference available to all doctors' wives. For those in Southern Ohio, a meeting will be held October 8, 1968, at the Methodist Church in Washington Court House. For Northern Ohio, the meeting will be at the Marion Country Club, Marion. Do plan to come to the meeting convenient to you. You will find that it will be a day well spent, as you meet other doctors' wives and share with them in all the many interesting and inspiring projects being accomplished.

If you have any questions about Fall Conference or about joining the Auxiliary, as a member of a County Auxiliary or as a Member-at-Large, please contact me.

I do hope to meet you, at Washington Court House October 8th, or at Marion on October 9th.

Sincerely,
(Mrs. R. H.) Ruth Williamson
Membership-at-Large Chairman

Doctors' Wives Needed

Doctors, could you please take a few moments from your busy schedules to urge your wives to join us at Fall Conference? We want to get to know all of them and let them see how they too, can be a part of the Medical Auxiliary picture — see how much the Auxiliary needs their special talents and how much it can give them in return in the sheer joy that comes from participating in an organization that is designed to assist our doctors in every way possible to establish rapport with the peoples of the state and of the world.

Our plans and programs are far-reaching in scope. I like to think that Mrs. C. C. Long, president of the Woman's Auxiliary to the AMA, announced her presidential theme, "Accent on Youth," she meant not only an accent on youth per se, but on youth at all ages and all levels. We are basically as young as we feel and to feel young we have to participate and be forward in thinking — "be with it," as the saying goes.

An Auxiliary Member can become involved in Legislation; Health Careers; Community Health Programs; the GEMS Program (Good Emergency Mother Substitutes) — a program that teaches safe baby sitting to teenagers); Educational and Counseling Programs; Physical Fitness Programs; Screen Testing in Schools; Fund Raising for AMA-ERF; Mental Health Programs; Safety and Disaster Preparedness Programs; and many other equally stimulating involvements. So come, meet with us on October 8 or 9 and choose the special interest you wish to follow.

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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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349-8

Ad Astra

Eugene Aras, M. D., Piqua; medical degree from the University of Kaunas, Lithuania, 1943; aged 50; died July 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Aras was born in Russia of Lithuanian parents and after coming to this country was licensed to practice in Ohio in 1951. He had been a practicing physician in the Piqua area for 14 years, after moving there from Fredericksburg. A member of the Lutheran Church, he is survived by his widow, two sons, and a daughter; also a brother in Lithuania.

Paul Richard Ensign, M. D., LaJolla, Calif.; Ohio State University College of Medicine, 1920; aged 74; died April 21; former member of the Ohio State Medical Association. Practitioner some years ago in Ashland and in Toledo, Dr. Ensign moved out of the state in the 1940's.

Charles Herbert Garvin, M. D., Cleveland; Howard University College of Medicine, 1915; aged 77; died July 17; member of the Ohio State Medical Association and the National Medical Association; Fellow of the International College of Surgeons; member of the American Venereal Disease Society. A practitioner of long standing in Cleveland, Dr. Garvin was formerly on the faculty of Western Reserve University School of Medicine and on the urology service of University Hospitals. He was a veteran of World War I, having served as medical officer in the Armed Forces. Active in community affairs, he was a member of the Urban League, the NAACP, and a member and former president of the board of the Cleveland Public Library. He was associated in practice with his son, Dr. Harry C. Garvin, who survives. Other survivors are his widow and another son.

James Alphonse Gavin, M. D., East Cleveland; St. Louis University School of Medicine, 1933; aged 62; died July 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Gavin was a practitioner of some 30 years standing in the East Cleveland area. Affiliations included membership in the Catholic Church. His widow and a sister survive.

Peter F. Gulmi, M. D., Strongsville; St. Louis University School of Medicine, 1938; aged 54; died July 27 as the result of injuries received in a traffic accident; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Abdominal Surgeons. Dr. Gulmi was a native of the Cleveland area and served most of his professional career in that vicinity. During World War II he was a captain in the Medical Corps. Among survivors are his widow, two daughters, two sons, a brother, and five sisters.

Wayne Beatty Hardin, M. D., Youngstown; University of Iowa College of Medicine, 1944; aged 50; died July 13; recent member of the Ohio State Medical Association, and the American Medical Association; member of the American Thoracic Society and the Industrial Medical Association. Dr. Hardin came to Ohio to take intern and residency training at the Youngstown Hospital Association, entered military service, and returned to continue residency training and later to enter practice. Among affiliations he was a member of the board of the Mahoning County Tuberculosis Sanatorium and was a member of the Methodist Church. Survivors include his widow, a son, two daughters, and his mother.

Raymond Albert Klingler, M. D., Baltic; Hahnemann Medical College of Philadelphia, 1952; aged 50; died July 8 in a traffic accident while traveling in Colorado with his family; member of the Ohio State Medical Association. A native of Holmes County, Dr. Klingler practiced in the Sugarcreek and Baltic area for about 15 years. The accident was a family tragedy, taking the lives of a daughter, a son-in-law, and a grandson. Injured were Mrs. Klingler, a son, and a daughter. Other survivors are another son, Dr. Klingler's parents, and three sisters.

John W. Larcomb, M. D., Westerville; Ohio State University College of Medicine, 1924; aged 70; died July 20; member of the Ohio State Medical Association. Retired in recent years, Dr. Larcomb practiced for some 34 years in Columbus where he specialized in pediatrics. For many years he was on the faculty of the OSU College of Medicine, and was physician for the Ohio Schools for the blind and deaf. Among affiliations, he was a member of the Moose Lodge, the Episcopal Church, and the Wheaton Club, and was a veteran of World War I. During recent years he was superintendent of the

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Henry Leo Sowash, M. D., Sandusky; Ohio State University College of Medicine, 1917; aged 79; died July 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Sowash devoted most of his professional career to practice in Sandusky and its vicinity. For many years he served as physician to the local board of education. He was a veteran of World War I and a member of the American Legion. Other affiliations included memberships in the Lutheran Church, the Odd Fellows Lodge, and several Masonic bodies. His widow and a brother survive.

Anthony J. Telego, M. D., Grand Rapids, Mich.; Marquette University School of Medicine, 1949; aged 50; died July 18. Dr. Telego practiced for a short time in Youngstown before moving to Grand Rapids where he was pathologist at the Butterworth Memorial Hospital. Survivors include his widow, two sons, his father, and four brothers.

John Henry Tildes, M. D., Lakewood; University of Michigan Medical School, 1933; aged 61; died July 5; member of the Ohio State Medical Association, the American Medical Association; American College of Obstetricians and Gynecologists; the International College of Surgeons; and the American Society of Abdominal Surgeons. Dr. Tildes devoted some 35 years to practice in the Greater Cleveland area, specializing in obstetrics and gynecology. Among affiliations he held memberships in several Masonic bodies. His widow and two sisters survive.

Ralph Leo Zucker, M. D., Toledo; Washington University School of Medicine, 1938; aged 55; died July 20; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A lifelong resident of Toledo, Dr. Zucker was in part-time practice and was director of the Lucas County Diagnostic and Evaluation Clinic. He was a veteran of World War II, was on the board for the Ohio Division of the American Association for Maternal and Child Health, and was a member of the Temple. Surviving are his widow, a son, two daughters, and a brother.

Dr. Robert T. Gray, Prospect, for distinguished service to boyhood, received Scouting's highest award, the Silver Buffalo, at the 58th annual meeting of the National Council in Chicago.

Gastroenterology Course Offered By the Cleveland Clinic

The Cleveland Clinic Educational Foundation is offering a postgraduate course entitled "Upper Gastrointestinal Tract Disease — Clinical Aspects" on Wednesday and Thursday, November 6 and 7. Medical motion pictures related to the subject will be shown on Thursday evening preceding the program.

Guest speakers will include the following: Dr. Angelo E. Dagradi, Long Beach, Calif.; Dr. Frank B. McGlone, Denver, Colorado; Dr. Gordon McHardy, New Orleans; Dr. Robert S. Nelson, Houston, Texas; Dr. Eddy D. Palmer, East Orange, N. J.; Dr. Vernon M. Smith, Baltimore; and Dr. Regis A. Wolff, Pittsburgh. Some 14 members of the clinic medical staff also will be on the program.

Registration fee is $40.00 — acceptance in the order of application. Courtesy luncheons will be served on Wednesday and Thursday, and a courtesy reception given on Wednesday evening.

Details may be obtained from Walter J. Zeiter, M. D., Director of Education, Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106.

Use and Abuse of Drugs for Youth Featured in Columbus Program

Speakers from the medical, legal, and educational fields will discuss the growing problem of our young people and drug abuse for Ohio physicians on Sunday, October 13, at the Neil House Hotel, 41 South High Street, Columbus.

Entitled "Youth and Drugs — Use and Abuse," the day-long session will include presentations by William R. Martin, M. D., chief, National Institute of Mental Health Addiction Research Center, Lexington, Kentucky; Margaret J. Forsythe, M. A., Ed. D., Dean of Women at Ohio Wesleyan University, Delaware; Humphrey Osmond, MRCP, DPM, director, Bureau of Research in Neurology and Psychiatry, New Jersey Neuro-Psychiatric Institute, Princeton, New Jersey, and C. William O'Neill, Justice of the Ohio Supreme Court and former Governor of Ohio.

The conference is being cosponsored by the Ohio State Medical Association, the Ohio Education Association, the Ohio Psychiatric Association, the Ohio Academy of General Practice, and the Ohio Department of Mental Hygiene and Correction.

The program will conclude with a panel discussion and question-answer period. Panel moderator will be Victor M. Victoroff, M. D., Cleveland, past president of the Ohio Psychiatric Association and current member of OSMA's Committee on Mental Health. Resource psychiatrists from the OPA will be situated throughout the audience to relay questions and stimulate discussions.

A program and registration form were included in the last *OSMAgram*. Completed registration form and check for $5 registration fee should be sent to: Secretary, Committee on Mental Health, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. The registration fee includes a luncheon and two coffee breaks. Additional registration forms may be obtained from the secretary of the committee.

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State Mental Hygiene Physicians To Hold Meeting in Columbus

The Association of Physicians of the Ohio Department of Mental Hygiene and Correction will hold its next meeting at the Columbus State School, Columbus, on Friday, October 4. The meeting will be open at 9:00 A. M.

In the morning, Edmund Foley, M. D., professor emeritus, University of Illinois Medical School, Chicago, will speak on a topic to be announced.

Marshall Ginsberg, M. D., Department of Psychiatry, University of Cincinnati, will talk in the afternoon on the subject, "Community Psychiatry and Mental Health."

This is to be a combined meeting with the Ohio Association of Psychiatric Clinic Directors. Election of officers will be held and a medical movie sponsored by the Schering Corporation will be shown.

Additional information may be obtained from Virgina S. Edwards, M. D., Secretary-Treasurer, Columbus State School, 1601 W. Broad Street, Columbus 43223.

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Symposium on Cancer Is Offered by Children's Hospital, Columbus

Children's Hospital, 561 South 17th Street, Columbus, in association with Ohio State University College of Medicine is presenting a one-day symposium entitled "Combating Children's Cancer," on Wednesday, October 9, from 9:00 A. M. to 4:00 P. M.

The symposium is especially directed to all who are confronted with cancer among children. Sessions on diagnosis, surgical management, radiation and drug therapy and on the team approach used at Children's Hospital will be presented.

No registration fee is required since the symposium is supported in part by a U. S. Public Health Service grant. Additional information may be obtained from L. D. Samuels, M. D., chief of the Radioisotope Laboratory at Children's Hospital, and assistant professor of pathology and pediatrics at OSU.

Following is the tentative list of participants. Appointments, unless otherwise indicated, are on the Ohio State University College of Medicine faculty or Children's Hospital staff.

Giulio J. D'Angio, M. D., professor of radiology, Cornell University Medical College, and director of radiation therapy, Memorial Hospital for Cancer and Allied Diseases.

M. Lois Murphy, M. D., Division of Chemotherapy, Memorial Hospital for Cancer and Allied Diseases, New York City.

Frank Batley, M. D., professor of radiology and director of radiation therapy.

E. Thomas Boles, M. D., associate professor of surgery.

Joyce Case, R. N., cancer chemotherapy nurse.

H. William Clatworthy, M. D., professor and head of the Division of Pediatric Surgery.

Inta J. Ertel, M. D., assistant professor of pediatrics.

Thomas J. Frye, M. D., radiologist, and assistant professor of pediatrics.

James Kilman, M. D., assistant professor of thoracic surgery.

Thomas S. Morse, M. D., associate professor of pediatric surgery, and director of student teaching.

W. A. Newton, Jr., M. D., director of laboratories, professor of pediatrics and chief of pediatric pathology.

Dr. Samuels.

Martin P. Sayers, M. D., associate professor and

(Continued on Next Page)

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chief Pediatric Section, Division of Neurological Surgery.

Betty Younger, B.S.W., cancer grant social worker.

Program

What and Where the Tumor?

Radiological Techniques — Dr. Frye
Radioisotope Scans — Dr. Samuels
Laboratory Tests — Dr. Newton
Discussion — Dr. Murphy

Therapy: The Knife —

Liver and Kidney Tumors — Dr. Clatworthy
Neuroblastoma — Dr. Boles
Pulmonary Metastases — Dr. Kilman
Brain Tumors — Dr. Sayers
Discussion — Dr. Morse

Therapy: The Beam and Chemotherapy —

New Directions in the Radiation Therapy of Children — Dr. D'Angio
Discussion — Dr. Batley
Current Chemotherapy at Columbus Children's Hospital — Dr. Newton
Asparaginase and Experimental Chemotherapy — Dr. Murphy
Discussion and Cooperative Studies of Chemotherapy — Dr. Ertel

The Team —

Paramedical Personnel — Dr. Samuels
Nursing — Mrs. Case
Social Service — Mrs. Younger
Discussion and Closing Comments—Dr. Newton.

Columbus Facility Is Equipped To Treat Women Alcoholics

Maryhaven, Inc., is described by its sponsors as a unique community resource that is specifically designed for the rehabilitation of women alcoholics. In this respect it is an example of Ohio facilities that are updating their programs to meet the growing national problem of alcoholism — a problem that is gaining the attention of civic leaders, physicians, clergymen, and other citizens.

The facility, located in downtown Columbus at Latta Avenue and East Broad Street, has undergone changes in recent months. The admission procedure and the therapy program are under medical supervision. The directive staff has both training and experience, and a group of interested men and women, the board of trustees, are responsible for the development of policies.

Thirty women residents and out-patients, the sponsors point out, are enabled to bridge the gap between intoxication and a return to employment, family life and independence, under the guidance of interested personnel, visiting psychiatric and pastoral care counselors.

Maryhaven, Inc. has recently received encouragement and support from individuals and organizations, namely, the Department of Health of Columbus, The Columbus Foundation, the Jeffrey Foundation, Wolfe Associates, and a medical advisory board of physicians through the Columbus Academy of Medicine. Maryhaven, Inc. has been accepted as a member agency by the United Community Council, effective January, 1969.

Referrals or the opportunity to tell individuals and groups about the Maryhaven program will be welcomed by the administrative staff. The Columbus telephone number is 252-2179.

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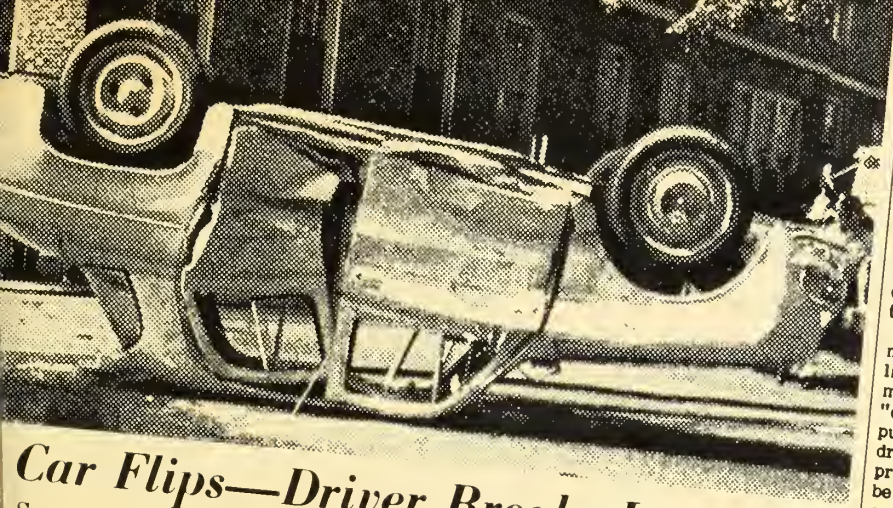
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Car Flips—Driver Breaks Leg

Sept. 7. John P. Jones of incurred a broken leg today driving

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its top. Hasn't he

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He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic 1/4 grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

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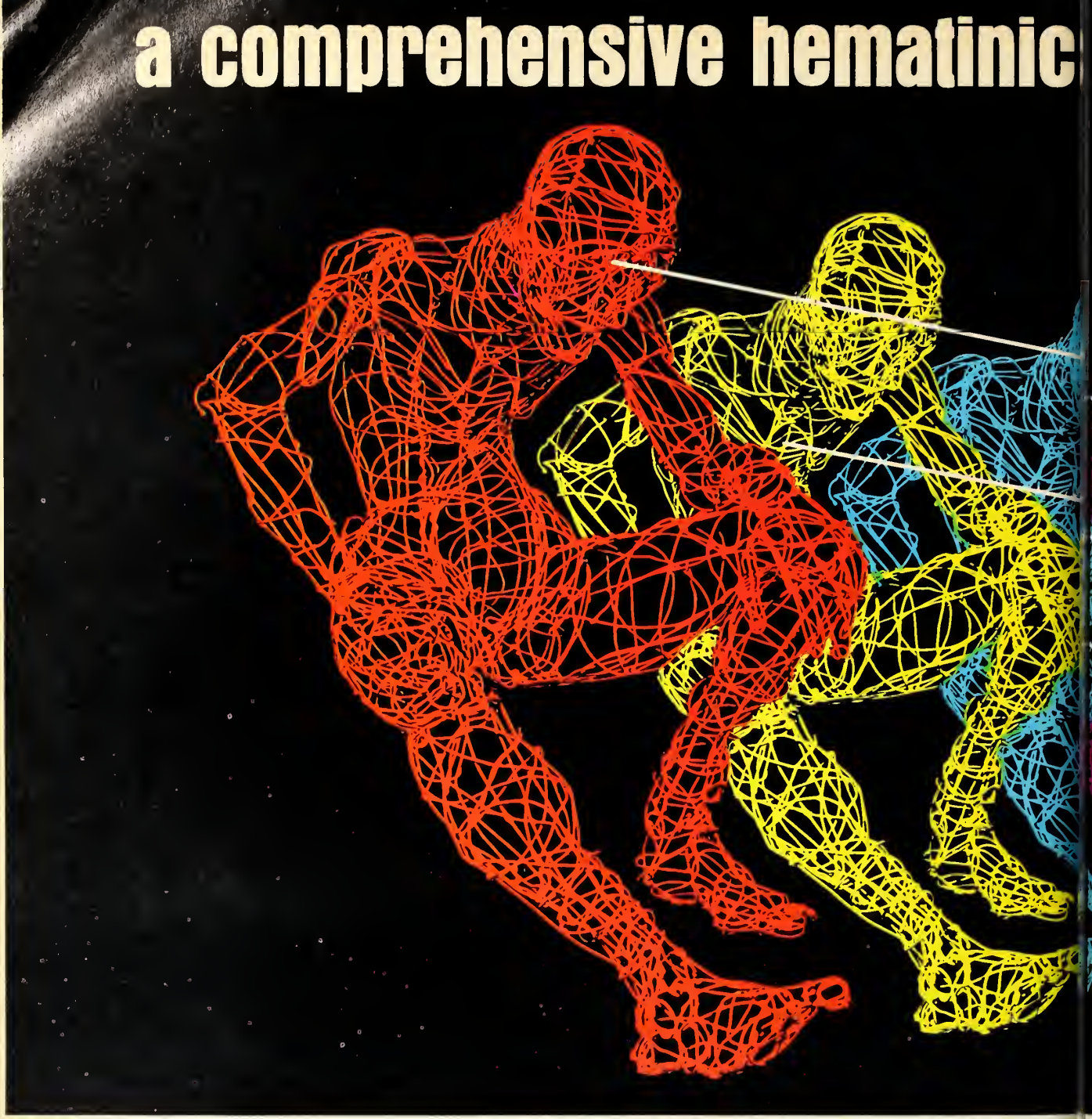
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Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

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Diabetes Course Scheduled in Columbus, October 10

The Central Ohio Diabetes Association and Ohio State University College of Medicine are sponsoring a course entitled "Diabetes Mellitus: Insulin, Lipid Metabolism, Obesity," on Thursday, October 10. Meeting place is the Imperial House North, Morse Road and Interstate 71 in North Columbus. The course is approved for credit by the American Academy of General Practice.

Registration fee is $20, and reservations may be made with the OSU Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 W. Tenth Avenue, Columbus 43210.

Following are features of the program, beginning at 9:00 A. M.

Welcome by Richard L. Fulton, M. D., Columbus, president of the Central Ohio Diabetes Association.

What's New in Diabetes as Seen from the Editor's Desk — Harvey C. Knowles, Jr., M. D., professor of medicine at the University of Cincinnati, president of the American Diabetes Association, and editor of *Diabetes*.

Carbohydrate Intolerance, Insulin Hypersecretion, and Premature Coronary Disease — Manuel Tzagournis, M. D., OSU assistant professor of medicine.

The George J. Hamwi Memorial Lecture — **Insulin, Obesity, and Starvation** — George F. Cahill, Jr., M. D., associate professor of medicine and director, Elliott P. Joslin Research Laboratory, Harvard University.

Insulin Secretion in Normals, Obese and Diabetic Patients — Buris R. Boshell, M. D., professor of medicine, Medical College of Alabama, Birmingham.

The Cause and Prevention of the Epidemic of Atherosclerosis in the Diabetic Patient — Daniel B. Stone, M. D., professor of medicine, University of Iowa School of Medicine, Iowa City.

Panel Discussion with Thomas G. Skillman, M. D., professor of medicine, and director of the Division of Endocrinology and Metabolism at OSU, as moderator, and the foregoing speakers as panel members.

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306 High Street

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Box 1272

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316 Michigan St.

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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

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Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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31 OCT 1968

The OHIO STATE MEDICAL Journal

Published By The Ohio State Medical Association

OBER 1968
64 ★ NUMBER 10

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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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VOL. 64 OCTOBER, 1968 No. 10

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Address All Correspondence:
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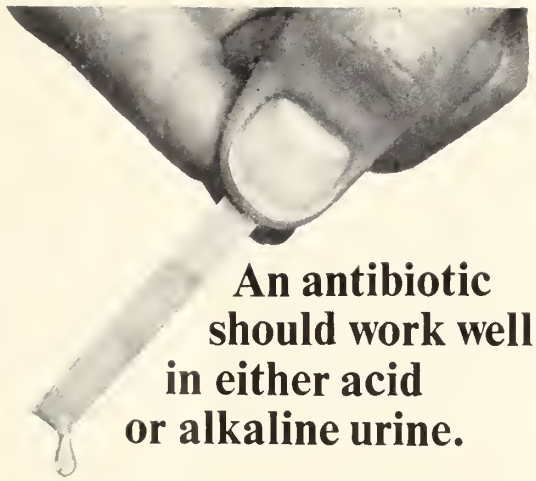
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Ohioans Are Among Many Civilian Doctors in Vietnam Project

As of July 1, 24 Ohio physicians had been among 483 doctors who served 60-day service tours under the AMA-sponsored Volunteer Physicians for Vietnam project, according to a status report from that organization. Of that number, 24 were Ohio physicians.

Actually, 450 individuals participated; 25 of these served two tours, and four returned to serve three tours each. Over a three-year period, these physicians contributed more than 80 man-years of voluntary service. In effect, an average of 30 physicians has been maintained in Vietnam at all times since the American Medical Association became responsible for this program in the summer of 1966; an average of 35.0 for the past six months.

These U. S. licensed physicians were recruited from 49 states, the District of Columbia, the Canal Zone, and from seven overseas. Fourteen women physicians have participated; two of these have served extended tours. Twelve former volunteers have subsequently returned to Vietnam as long-term employees supporting the USAID medical mission. Two former volunteers in July were preparing to return to Vietnam as medical missionaries.

Thirty-two physicians are needed every 60 days to maintain this program. Most needed are general practitioners, internists, pediatricians, and general surgeons, with an immediate demand for orthopaedic surgeons and ophthalmologists.

Health Education Materials Available from the AMA

One of the primary objectives of the American Medical Association as stated in its Constitution is "to promote . . . the betterment of public health."

Distribution of health pamphlets and posters is one of several ways the AMA goes about promoting better health to the general public. A pamphlet catalog describes in details the nearly 100 pamphlets and sets of full-color posters available at the Chicago office.

Health materials may be ordered singly, or in quantity for distribution through organizations. Such materials are recommended:

For physicians to supplement their counsel to patients;

For business organizations, clubs, or other groups for distribution;

For teachers, athletic coaches, etc., to be used as instructional material.

Write the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.



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DOW

Health Insurance Institute Predicts New Baby Boom

The United States may soon be in the midst of another population explosion, the Health Insurance Institute anticipates.

Current estimates are that the nation can expect a new baby boom within five to ten years — possibly sooner.

The prediction is made despite last year's rate of 17.9 births per 1,000 population — the lowest annual rate on record. Total births in 1967 were 3,533,000, almost 100,000 fewer than the year before.

While some demographers use these figures to make a case against a population jump, others predict that the problems of a growing population are just ahead.

These experts say there will be record numbers of babies born in the 1970's, with a good chance that the population will double and reach 400 million persons by the end of the century.

The rise in marriages to 1,913,000 last year — the fifth successive year there was an increase — is one indicator.

Another is that a new crop of eligible husbands is now coming of age — young men between 21 and 24, in short supply since 1956.

For every 100 marriageable young women, the Institute estimates, there are only 91 marriageable young men.

By the 1970's, this disparity is expected to be corrected.

According to the Information Center on Population Problems, "there is good reason to anticipate a new — and perhaps bigger — baby boom at the end of the decade."

Some birth experts point out that despite the use of birth control pills, the size of families will not necessarily be reduced. The pills are used frequently, they say, only to allow couples to space their offspring more conveniently.

But however the baby population fluctuates, the Health Insurance Institute says the traditional peak baby months of summer are expected to continue.

During July, August, and September of 1968, if past years are any indication, about one million babies will be born in the United States.

Grant Advances Studies on Clot Dissolving Agent

The University of Cincinnati Medical Center has received a $45,000 contract from the U. S. National Heart Institute for studies to establish the effectiveness of a clot dissolving agent (urokinase) against clots obstructing blood vessels in the lungs.

Principal investigator is Dr. Noble O. Fowler, professor of medicine. He is also director of the University's Cardiovascular Research Laboratory at Cincinnati General Hospital.



"COCA-COLA" AND "COKE" ARE REGISTERED TRADE MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT!
ROBITUSSIN®



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Pheniramine maleate . . . . . 7.5 mg.
Codeine phosphate . . . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS



Geigy



Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Regroton produces a smooth, long-acting effect that usually reduces both systolic and diastolic pressures. At the same time it often acts to allay anxiety and nervous tension associated with hypertension.

Although Regroton is generally well tolerated, adverse reactions may occur. This drug is contraindicated in mental depression, demonstrated hypersensitivity, and most cases of severe renal or hepatic diseases. For a complete list of side effects, please see the Prescribing Information summarized on the following page.

Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.



One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C

For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6228

Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action — analgesic, decongestant and antihistaminic — is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

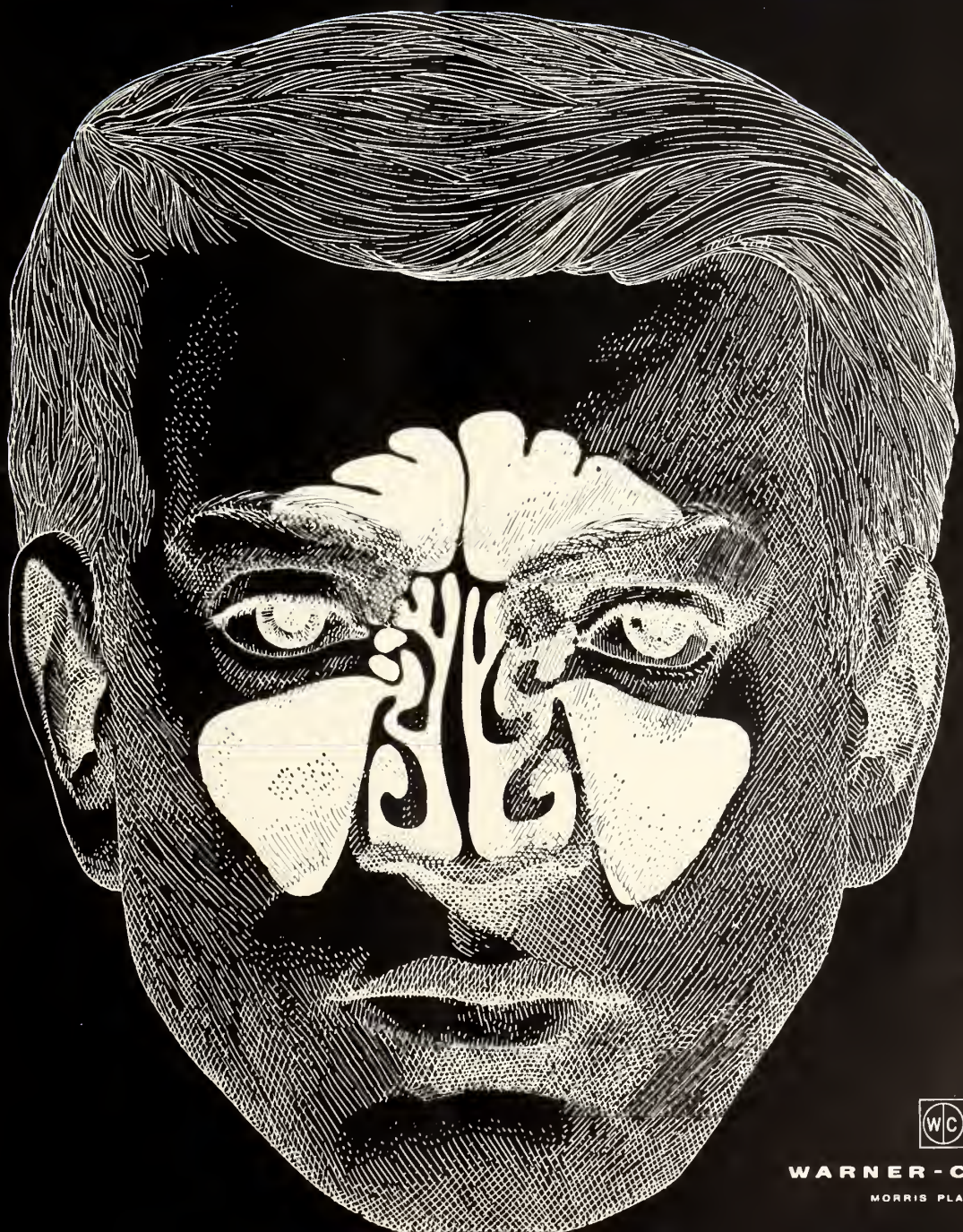
PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults — 2 tablets every 4 hours.
Children (6-12 years) — ½ the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Source of Symptomatic Relief

Sinutab® | 2 tabs. q.4h.



WC

WARNER-CHILCOTT

MORRIS PLAINS, N.J.

In Our Opinion

Comments on Current Economic, Social And Professional Matters

CONTINUING EDUCATION HIGH AT AMA CLINICAL CONVENTION

Well known in our day is the explosion of scientific knowledge and technology and the subsequent demand on the physicians' time, intellect, and ingenuity. On top of it all, never has there been a greater demand for physicians' services.

These factors combine to burden the busy physician in his efforts to keep abreast of modern developments in medicine. There is an abundance of fine scientific literature. There are abstracting services, computerized data, recordings that the busy doctor can turn on at his leisure, and source material without end. But there is nothing that can take the place of eyeball to eyeball conversation between doctor and doctor whether it be on the exhibit floor, in the lecture room, or during informal conversation.

Such a forum for the exchange of ideas is the coming Clinical Convention of the American Medical Association in Miami Beach, December 1-4. The AMA Clinical Convention is designed primarily for the man in practice. Speakers have been selected to bring practitioners the latest findings in their respective fields of interest. Exhibits offer perhaps one of the most informal means of communication between doctor and doctor.

Whatever the actual means of communication, there is an unprecedented emphasis on and need for continuing education. The Clinical Convention promises to be a stimulating four days, worthy of the busy physician's time. Every physician is urged to take advantage of this educational opportunity.

GETTING INVOLVED IN PUBLIC RELATIONS AND PUBLIC AFFAIRS

The importance of physicians' roles in public relations and public affairs was ably discussed by panelists at a recent Public Affairs and Public Relations Conference of the Texas Medical Association.

Sounding the keynote of the matter, Philip Lesley, Chicago public relations counselor, said in part:

"The traditional lifetime relationship between doctor and patient is fast becoming history as specialization becomes more commonplace. Ignorance of the medical profession breeds fear in the public; and, as technology advances, the gulf between physician and patient grows wider. But the public's anxiety and distrust can be alleviated if doctors will arm themselves with some knowledge of the mechanics of good public relations."

Dr. Otis Wolfe, past president of the Iowa Medical Society, put the matter in perspective for the individual physician when he said: "The cure (better public relations) lies not on a large scale but rather on a person-to-person level. It is on the individual basis that most people receive their first and most lasting impression of medicine." He did not minimize the need for broad public relations programs, but advised doctors to continue to attend courses in human relations, communications, and the art of medicine.

In our opinion it is significant that both of these speakers — one looking from outside the medical profession in, and the other from the inside out — come to virtually the same conclusion: That good public relations starts with good relations between doctor and patient and between doctor and community.

The art of medicine continues to be the number one bridge between doctor and patient, but all physicians would do well to take the foregoing advice and "arm themselves with some knowledge of the mechanics of good public relations."

MORE EVIDENCE PILING UP UNDER GENERIC-BRAND NAME CONTROVERSY

Despite increasing evidence "that something may be wrong," certain politicians and governmental officers are still trying to foist off on the public laws that would make generic drug prescribing compulsory under government medical care programs.

Under the title, "Absorption Rates Vary — Brand, Generic Drugs Differ in Man," the *Journal of the AMA* in its August 26 issue reports progress on another study in this field. Dr. Christopher M. Martin, director of the Georgetown Laboratory of Clinical Pharmacology, reported in part: "What we have found, when drugs are tested in man, are differences between brand and generic forms that may or may not

be significant in the actual treatment of disease. It is only inferential evidence that something may be wrong."

Another physician active in the pharmaceutical research field, Dr. Max S. Sadove, of Chicago, has pointed out numerous times that side effects may differ widely between brand name and generic drugs.

More and more evidence is piling up indicating that blanket substitution of generic for brand name drugs is not in the best interest of the patient.

RX NEEDED FOR PROTECTION AGAINST OFFICE BURGLARIES

Clippings from newspapers are a constant reminder that physicians' offices are particularly vulnerable to burglaries. The lawbreakers run the gamut from professionals seeking narcotics to youngsters bent on petty thievery.

Doctors would do well, therefore, to take more than the ordinary precautions in securing their offices and in carrying protective insurance. A request for advice from local law enforcement officers might bear out the adage that an ounce of prevention is worth a pound of cure.

OSU and Battelle Pool Resources On Aerospace Medicine Data

Ohio State University's Department of Preventive Medicine and Battelle Memorial Institute of Columbus are teaming up to provide a unique information-collecting service for the National Aeronautics and Space Administration.

The two agencies will delve into current research activities in aerospace medicine in order to assess the present state of the art. Estimated cost of the one-year effort is $175,000. The cost reimbursable contract was effective June 17, 1968.

Battelle and Ohio State will provide three kinds of information reviews. One is a quick-response study which will provide a comprehensive analysis of the problem area in a matter of days or weeks. Long range definitive studies involving several weeks or months will also be made available when needed by NASA. Also, the two research agencies will conduct symposia where noted authorities in particular areas of aerospace medicine can be called together for "brain-tapping" sessions.

Dr. Harold V. Ellington, chairman of the Department of Preventive Medicine at Ohio State, pointed out the great need for a resource-assembling program of this type, since a variety of research is being carried out in the field of aerospace medicine by independent and government agencies, teams, and individuals.



After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.



New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during July. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Crawford
Carmelo S. Fabrigar, Bucyrus

Cuyahoga
John T. Bover, Cleveland
Ranendra Das Varma, Cleveland
David J. G. Fergusson, Cleveland
Ildefonso M. DeLa Rosa, Cleveland
Donald D. Kim, Cleveland
M. Kamel Lahham, Cleveland
Rita M. P. Nassif, Cleveland
Mariano Q. Pizarro, Bedford

Franklin
G. James Cerilli, Columbus
Richard D. Ruppert, Columbus
Harry S. Turner, Columbus

Hamilton
William B. Hofmann, Cincinnati
Harry Horwitz, Cincinnati
Samuel M. Wigser, Cincinnati

Jefferson
Sadri Alavi, Steubenville

Lucas
Eleuterio G. Lim, Toledo

Portage
Kevser A. Apaydin, Alliance

Williams
Gerald R. Bougher, Bryan
Shelby O. Cooper, Bryan

* * *

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during August. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Cuyahoga
Arthur D Stefee, Jr., Cleveland

Franklin
Philip A. Bromberg, Columbus
Lawrence G. Hornsby, Columbus
Paul J. Matrka, Columbus
Alfred F. Shoman, Jr., Columbus

Summit
Richard K. Brooks, Connellsville, Pa.
Jay Richard Gold, Akron
John A. Karnoupakis, Cuyahoga Falls

Trumbull
Arthur G. Schuring, Warren

Human Hair May Be Cue to Certain Environmental Health Factors

The environmental relationship of certain metals, not essential to the body but found in human hair, is under study at the University of Cincinnati Center for Study of Human Environment.

Associate Professor Harold G. Petering reported recently at the Second Western Hemisphere Nutrition Congress in San Juan, Puerto Rico, on work he and David W. Yeager are doing on cadmium, lead, and other metal content of human hair.

The research team is seeking for environmental factors or evidence of chronic disease associated with alterations in metal content of the hair. The project is supported by a U. S. Public Health Service grant.

nce-popular treatment for back pains
to have the seventh son of a seventh son
d or walk on the patient's back.



eadache, a sovereign remedy was
ar a snakeskin round one's head.



The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.



A realistic approach to pain relief



mpirin'®

mpound with Codeine hosphate gr. 1/2 No. 3

tablet contains:
ine Phosphate gr. 1/2 (Warning—
e habit forming), Phenacetin gr. 2 1/2,
in gr. 3 1/2, Caffeine gr. 1/2.

eps the promise pain relief

Co.' narcotic products are
B", and as such are available on oral
tion, where State law permits.

URROUGHS WELLCOME & CO. (U.S.A.) INC.
uckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the d should be discontinued.
2. Liver function tests must be performed at regular intervals during ment with this drug since liver damage may occur during therapy. T drug should be discontinued immediately in cases of aggravated li dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and to etry, are recommended for patients being treated with this drug sin many phenothiazines and related drugs have been shown to cause changes.
4. Complete urinalysis and BUN should be done on patients treate Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranuloc eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalitie liver function tests, cholestatic and hepatocellular jaundice, urinary f quency, acute urinary retention, oliguria with elevated blood pressu albuminuria, glycosuria, elevated BUN, microscopic deposits in the u impotence, disturbances of coordination, confusion, headache, fatig blurred vision, transient diplopia and oculomotor disturbances, spee disturbances, abnormal involuntary movements, peripheral neuritis a paresthesias, depression with agitation, talkativeness, nystagmus, ti nitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndro photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, e multiforme and nodosum, aggravation of disseminated lupus erythe tosus, gastric distress, abdominal pain, diarrhea, constipation, ano dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypo tension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular e are drug-related is not known. However, some of these complications resulted in fatalities.) The necessity for discontinuing the drug should dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with me if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the should be increased in one-half tablet (100 mg.) increments every 12 until freedom from pain is achieved. To relieve pain, between 200 mg 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patien with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should b made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geig

uncommon relief of uncommon pain



The Divorced Depressive: "Forty, Forgotten

"Had a large wedding."
"Had a fine home and family."



TO-5757

Forlorn"

divorce."
eal loser,
o are
ds."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

in depression



Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

Cincinnati Physician Volunteers for Medical Tour in Afghanistan

Dr. Harry R. Mendelsohn, assistant chief of outpatient service at the Veterans Administration Hospital, Cincinnati, volunteered to serve the month of September in Afghanistan with MEDICO, a service of CARE. Actually, Dr. and Mrs. Mendelsohn volunteered as a team — he as a physician and she as a nurse and teacher. Area of service was Avicenna Hospital in the Afghan capital of Kabul.

Dr. Mendelsohn was the 1958 recipient of the Daniel Drake award presented by the Academy of Medicine of Cincinnati for outstanding community and professional service.

MEDICO's goal in Afghanistan is to help bring modern facilities to the Asian kingdom, by supervising patient care and advancing the training of local staff. MEDICO participates in a formal training program both in surgery and medicine, conducted at the 85-bed Avicenna Hospital, for Afghan medical school graduates.

Augmenting the permanent MEDICO team, whose members serve two years, are volunteers like Dr. Mendelsohn who go at their own expense for month-long tours to heal and teach.

MEDICO currently has seven long-term teams based at hospitals in Malaysia, Afghanistan, Tunisia, Algeria, the Dominican Republic, and Honduras.

Text Deals with Legal Angles Of Personal Injuries

Personal Injury Annual — 1961. This is one of a number of texts published by Matthew Bender & Company, Inc., 235 East 45th Street, New York City, on various phases of legal medicine. Written from the practicing attorney's point of view, the text is of value to physicians who may wish to brush up on the medico-legal aspects of injuries, or keep a text on hand for ready reference.

Compiled from *Personal Injury Newsletter* and other legal sources, the book features articles by such authorities in the field as Attorney William E. Knepper, of Columbus, Dr. Keith E. Weigle, of Cleveland, and many others. Additional information may be obtained from the publisher at the foregoing address.

Dr. Sheldon Rogers, clinical director of the Portsmouth Receiving Hospital, was designated by the Ohio Department of Mental Hygiene and Correction as its delegate to the International Health Conference in Copenhagen, Denmark.



THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

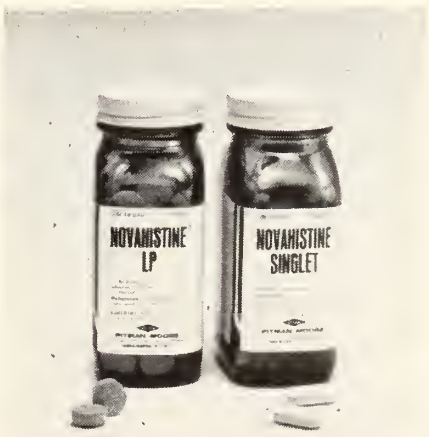
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



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The majority of these patients could take Magan and obtain the benefit of salicylate therapy.

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(magnesium salicylate, W-T)

May be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

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A single chemical entity . . . no coating, no buffering, sodium free and non-acetylated.

Dosage: 1 or 2 tablets every 4 hours with a full glass of water.



Physicians Invited to Participate In Auto Safety Studies

Teams of physicians and police traffic officers have been proposed as a means of collecting vitally needed scientific data from auto accidents.

H. A. Fenner, Jr., M. D., Hobbs, N. M., chairman of the American Medical Association's Committee on the Medical Aspects of Automotive Safety, pointed out that every traffic accident presents an opportunity to discover clues to prevention.

"Most accident reports at the present," Dr. Fenner said, " are related to law enforcement rather than to research-oriented data collection.

"If we had a corps of knowledgeable, trained, and qualified physicians and police officers to provide accurate, scientific reports on a large number of accidents, automotive engineers would have the necessary data to translate into safer motor vehicles and highways."

Dr. Fenner noted that many of the safety devices on present-day automobiles and highways resulted from traffic accident research.

According to Dr. Fenner, the AMA Committee, along with the American Association for Automotive Medicine, is studying the possibility of working with one or more universities in the establishment of intensive courses in accident investigation.

Preliminary discussions have indicated that such a course would be of three days duration and would be limited to 200 teams, each consisting of a physician and a member of a police traffic department.

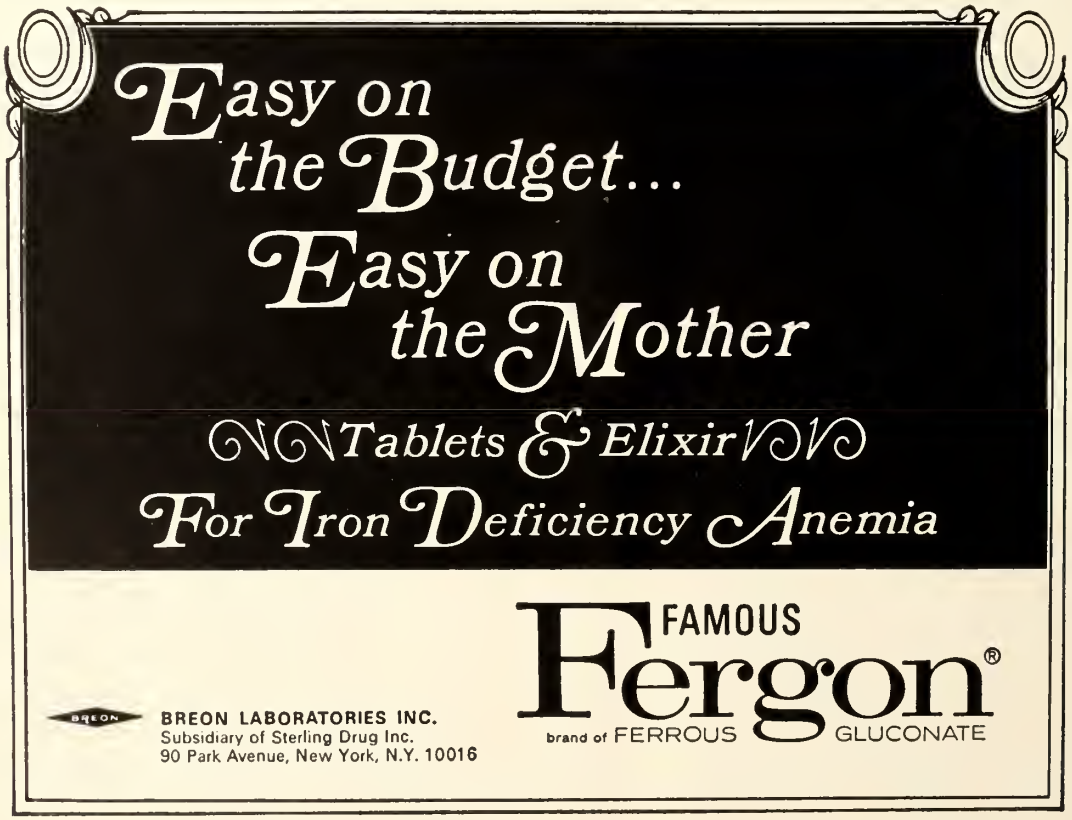
Dr. Fenner said the important need at the moment is to determine if enough physicians are interested in participating in such an effort.

Physicians who are interested in participating are asked to send their name, address, age, medical college, and field of practice to the Committee on Medical Aspects of Automotive Safety, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610.

Catholic Board Sends Supplies to Medical Missions Overseas

Shipments of drugs, medicines, and hospital supplies to overseas medical missions during the first half of 1968 totaled more than a million pounds and had a wholesale value of more than $4 million, reported the Catholic Medical Mission Board, 10 West 17th Street, New York 10011.

During the January-June period, the Board's placement desk cleared 64 medical-health volunteers — Catholic, Protestant, and Jewish, the Board reported — utilizing their professional skills in overseas missions. These volunteers included 15 physicians, 9 dentists, 24 nurses, 14 medical and dental technicians, a medical librarian, and a medical student.





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Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

What To Write For

Narcotics: Some Questions and Answers: This is one of a series of Public Health pamphlets on marihuana, LSD, amphetamines, and narcotics, intended for distribution in schools and in youth groups. It is PHS Publication No. 1827. Other pamphlets in the series deal with LSD (No. 1828), Marihuana (No. 1829), and the UP-and-Down Drugs (No. 1830). Single copies are available from the Public Information Branch, National Institute of Mental Health, Chevy Chase, Md. 20203. Copies in bulk may be obtained for 5 cents each — or $3.25 per 100 — from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

State Licensing of Health Occupations — This is a statistical study of the U. S. Public Health Service, a 172-page booklet including health occupations licensed by states; trends in occupational licensing; composition of licensing boards, etc. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price, $1.25.

Visits for Medical and Dental Care During the Year Preceding Childbirth — This is a narrative description and statistical report of a U. S. Public Health Service study in the United States for 1963. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price 45 cents.

American Social Health Association Schedules Meeting in New York

Venereal disease, infecting Americans at an unprecedented rate, will be topic A at the annual leadership conference of the American Social Health Association in New York City on October 27-28.

Leaders in the field in Great Britain and the U. S. will address themselves to the conference theme: "Venereal Disease Research Priorities: Biologic, Behavioral, and Control." A. J. Dalzell-Ward, Ph. D., medical director of the Central Council for Health Education, London, will deliver the keynote talk at the October 27 dinner meeting, opening the conference in the Biltmore Hotel. His topic will be "Britain's VD Education for High Risk Age and Cultural Groups."

Conference attendees can register early by forwarding a check or money order for $35, which covers the essential dinner and luncheon sessions, to the American Social Health Association, 1740 Broadway, New York, N. Y. 10019.

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See inside fold for product summary.

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

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Statistical Data on America's Young Men and Women

The population of the United States at ages 18-24 increased from 16.1 million in July 1960 to almost 22.3 million in mid-1967. This gain of 38 per cent was 3¾ times the growth rate for the population at all ages combined. Moreover, the number of young people is expected to continue increasing rapidly and may reach 29.6 million by 1980. Persons at ages 18-19 are expected to increase by 22 per cent, and those aged 20-21 by 29 per cent. There will be approximately 8.5 million men and women in each of these age groups by 1980. Even more marked growth is expected of the 22-24 age group: 45 per cent, to over 12.5 million in 1980. These trends will have an important impact on our social and economic life. The rise in college enrollments, family formations, and entrants to the labor force, which has already occurred, is likely to continue for at least another decade.

Of the total at ages 18-24 in 1967, including those in the Armed Forces overseas, over 19.5 million (about seven eighths) were white. The proportion was slightly higher for males than for females at each age period.

As is evident from the change in living arrangements between ages 18-19 and 22-24, early family formation is characteristic of American life. For example, among men 18-19 years of age, 81 per cent live with their parents or in another relative's household, but in the 22-24 age group only 36 per cent do. Over this same age span, men who are the head of a household increase from 5 per cent to 46½ per cent. This shift reflects the increasing numbers marrying at this period of life. Thus, the proportion of married men rises from 6½ per cent at ages 18-19 to about 54½ per cent for the 22-24 year olds.

Since females usually marry at younger ages than males, a much larger proportion of the women are married at ages 18 through 24. The proportions are 23 per cent for women aged 18-19 and 74 per cent for those 22-24 years. In consequence, women tend to change their living arrangements at an earlier age than the men. At ages 18-19, over 17 per cent are wives of household heads, and at ages 22-24 the proportion is as high as 64 per cent. Relatively few women head their own households at these ages: the proportion is less than 7 per cent even for those aged 22-24 years.

Increasing numbers of young people recognize the importance of formal education for meeting their future responsibilities. Over a third of the men at ages 18-19 attend college as full-time or part-time students. The proportion decreases as educational goals are met or for other reasons, but it still is as high as 17 per cent for those aged 22-24 years. Though fewer women than men are enrolled in school at these ages, the proportion attending college is 30½ per cent at ages 18-19 and 20 per cent at ages 20-21. In addition, 300,000 women aged 18-24 attend classes below the college level.

Our population at ages 18-24 has attained relatively high educational levels. Almost two-thirds of the men and three-fourths of the women have at least finished high school; 1.1 million have graduated from college. Only 8 per cent of the men and 6 per cent of the women have not completed one year of high school.

When in their late teens, 46 per cent of the men and 39 per cent of the women are in the labor force and not attending school. With advance in age, this proportion for men increases rapidly. Military service accounts for about 17½ per cent of the men, but is a negligible factor for the women. Civilian employment increases markedly for men, climbing to 62 per cent at ages 22-24. The proportion in the labor force and not in school also increases with age for women, but the rise is much less pronounced than that for men. In fact, over 45 per cent of the women at ages 22-24 are neither in school nor in the labor force. No doubt, a very large proportion are married and have young children in their care. — *Metropolitan Life.*

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On the next page is a summary
adverse reactions, contraindications,
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It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

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dearil, oxyphenbutazone:
brief summary see next page.

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TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions. The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

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Cincinnati Team Studies Impact of Environmental Factors on Health

Support for the idea that one's heredity is involved in whether or not a smoker develops heart and possibly respiratory symptoms has come from preliminary interpretations of a recent study of 8000 all-male United States twin pairs.

The survey of the 16,000 men was conducted last year by a research team from the National Research Council and University of Cincinnati Medical Center. Following up similar studies made earlier in Sweden, the survey sought information on effects of environment, such as tobacco smoking and air pollution, on certain heart and respiratory symptoms.

Dr. Edward P. Radford, director of the Department of Environmental Health at the University of Cincinnati, worked with two Swedish scientists who were visiting scholars at the University's Center for Study of the Human Environment during the time the study was done.

They are Dr. Lars Friberg, chief of the Department of General Hygiene in the National Institute of Public Health of Sweden and chief of the Institute of Hygiene in the Karolinska Institute, Stockholm, and Dr. Rune Cederlof, associate professor of the National Institute.

Support for the project came from the American Medical Association, U. S. Public Health Service National Center for Air Pollution, the National Institute of General Medical Sciences, and the Center for Study of the Human Environment at the Cincinnati University.

Men in the current American study are between 45 and 50 years of age, selected from the twin registry of veterans of World War II which was completed by the National Research Council in the spring of 1967. It serves as the largest major new resource for studying the relative influences of environment and heredity on chronic disease.

Goodrich Company Contributions Aid Medical Development Funds

The B. F. Goodrich Company recently announced payment of the third $5,000 installment on its five-year pledge of $25,000 to Case Western Reserve University Medical Center development fund.

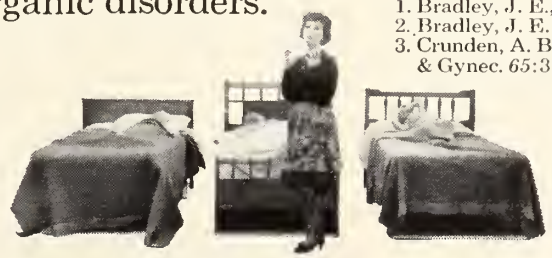
B. F. Goodrich Fund, Inc., has contributed more than $6 million since 1952 to assist educational institutions, hospitals, youth groups, welfare agencies and farm organizations. This year, the fund will grant colleges and universities $178,000 for operating funds and $70,000 for capital funds under its aid to education programs.



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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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The Historian's Notebook

From the Dresden Hygiene Museum to the Cleveland Health Museum

BRUNO GEBHARD, M. D., Cleveland, Ohio

PART II

(Concluded from September Issue)

Life in the Third Reich

In the spring of 1932 the family moved to Berlin. I was appointed Director of Research and Planning at the Exhibition Office of the City of Berlin. Besides large scale industrial exhibits, so-called *Kultur Ausstellungen* (Cultural Exhibits) were shown twice a year. This work kept me busy for the next couple of years. The construction of the exhibits took place in the Dresden Workshops. I was the idea man, was in charge of the over-all planning, and the liaison with the designers such as Herbert Bayer, Mies van der Rohe and other Bauhaus people.

I also had another mission. I was the contact man between the many government offices in Berlin and the Dresden Museum.

In January 1933 the political power was grabbed by the Nazis and my assignment became quite a delicate matter. Mrs. Gebhard and I belonged to a small group of intellectuals who shared the feeling of shock and shame about the political deterioration. We rallied in small private groups, often in our house in Templehof. Our publication, "Neue Blätter für den Socialismus" of which Henry E. Sigerist was coeditor, was soon *polizeilich verboten.* We tried to act according to our conscience. We were not willing to submit to the wrongdoings going on in Germany. This meant swimming against the stream. Some drowned; others retreated into the "Inner" Emigration; some of our friends went underground; most of us emigrated sooner or later.

I had refused to join the "Party" and soon became classified as "politically unreliable." But due to my technical know-how and, on account of my many foreign contacts, I still could do some major exhibition work, such as *Die Frau* (Woman), *Wunder des Lebens* (Wonder of Life),[4] and a cultural exhibition *Deutschland* for the Olympic Games in 1936.

As director of research and planning of these enterprises I had to take care of a wide range of prominent visitors, to name only a few: Nuntius Pacelli (later Pope Pius XII), Mr. and Mrs. Charles Lindbergh. It was also my dubious pleasure to meet Dr. Goebbels and the Fuehrer in person. They both came at night to view the exhibits — at 11 P. M. an hour after the public had left and extensive security measures had been taken. The irony was that during regular exhibition hours small political resistance groups met in the huge exhibition halls. They came from all over Germany since the special excursion trains were not checked for politically suspicious persons.

Life in those years was like walking a tightrope and after the Olympic Games I was dismissed from the German Hygiene Museum for "political reasons." I was only too glad to have survived two Gestapo hearings. We left Germany for good in September 1937 via the Paris Exhibition under the pretense of only a six-month stay in New York. This meant that we had to leave all our belongings behind and, far worse, our three young daughters. Friends helped to get them and my sister-in-law out in the spring of 1938, and the Gebhards started a new life in the U. S. A.[5]

New York World's Fair 1937-1940

My Berlin exposition, "Wonder of Life," had received complimentary reviews in the *American Journal of Public Health* and in the *New York Times* (August 14, 1935) by Waldemar Kaempfert, the leading science writer of his day. He wrote: "The Germans are probably the most skillful organizers of exhibitions in the world — there is a commendable lack of the racial twaddle that Hitler has made part of his gospel — there can be no question of the exposition's success as a piece of showmanship."

In other words, we had many friends who guided us in the (for newcomers) often mysterious ways of New York living.

My job as "Technical Consultant" to the American Museum of Health was to be the middleman between nearly two dozen scientific committees ranging from allergy to mental health, the commercial sponsors of the pharmaceutical industry, and our architects and designers. Great names in Medicine were connected with the projects such as Livingston Farrand, Hans Zinsser, Francis Rackermann, Alexis Carrel, Tom Rivers, and Robert L. Dickenson. Henry E. Sigerist helped in developing the exhibit, "The Maze of Superstition." The organizational *spiritus rector* was Homer N. Calver who had helped us to get out of Germany. Matters of policy were handled by Dr. George Baehr, the great leader of organized medicine in New York who was also Mayor La Guardia's personal physician. La Guardia of course had an overall interest in the World's Fair, but, having lost his first wife in child birth, he showed special interest in our section.

If success can be measured in numbers, we reached our goal. We had the second largest attendance, General Motors' "Futurama" being No. 1. Total attendance in the Hall of Medicine and Public Health was 12 million visitors during the two years of the Fair.

On September 1, 1939, the lights went out all over Europe. The Fair was continued for another summer but it was increasingly apparent that an American Museum of Health in New York City could not become a reality in the near future.*

Cleveland Health Museum 1940-1965

So far as one who has directed the growth of an institution for 25 years can be objective, I have tried to give an accounting in "Health Museums in the United States: Review and Outlook."[6] There are in addition nearly 100 articles about the growth and development of health museums in the U. S. A. dealing with different phases of museum work.

Here are some figures to measure these activities: the 900 founding and dues-paying members number over 7000; attendance has passed the 100,000 mark; the budget amounts to over $250,000 as compared with $25,000 in 1940. The total expenditure over 25 years is more than $3 million and most of it came in small amounts from contributors or represented earnings from workshop activities.

The First Year

Personally speaking, the Cleveland Health Museum was the famous "once in a lifetime" opportunity — a museum man's dream. Pioneering a new type of science museum to promote health education on a community basis was in itself a great challenge. The circumstances for a beginning were very favorable— an empty mansion, Dr. Dudley P. Allen's former home at 8811 Euclid Avenue; a gracious and generous benefactor, Mrs. Elisabeth Severance Prentiss; and the fact that I did not inherit any staff, collection, or exhibits. The only uncertainty more or less imposed on me on my first day of work was: Can the Museum be opened before the U.S.A. enters the war? On that day the *Plain Dealer's* headline (June 17, 1940) was "France Surrenders."—On November 13, 1940, the museum opened its door to the public. My good friend and counselor Howard Dittrick referred to it jokingly as "Another German Blitzkrieg."

The War Years

Pearl Harbor Day made the Gebhard family officially "enemy aliens," but for the museum it only meant that the work was stepped up with first aid courses and home nursing classes for the Red Cross. Many exhibits from the World's Fair were turned over to us for safekeeping during the duration. Cut off from Europe, we made many contacts in South America and helped to develop a Health Museum in Mexico City in 1943 and in Bogota, Columbia, 1944.

I got involved in some unforeseen assignments as in the training of future health officers in our armies of occupation both for Italy and Germany. In spite of the war with Germany, we became citizens of the U.S.A. in May 1944.—The same month also marked my first listing in *Who's Who in America*. With so many of my medical colleagues in the Armed Services I was in great demand as a radio speaker (Station WGAR), jointly with the Academy of Medicine and the Cleveland Dental Society.

The Museum Moves into Its Second Home

By the end of World War II it was evident that the museum needed more space to accommodate the increasing number of school classes, to house the newly acquired Robert L. Dickenson Collection[7] and to provide better facilities for the workshops. On May 1, 1946, we opened the building at 8911 Euclid Avenue to our visitors.

Voluntary health agencies are supposed to pioneer new methods and to demonstrate how new needs can be met. We tried to anticipate arising community problems. Some projects were proposed to us, others we initiated ourselves. One of our special exhibitions, "Live Long and Like It," (1946) after 25 years still is a going concern in the old age groups of the Cleveland Public Library.

In 1947 the first communitywide Diabetes Detection Center was established at the Museum. The following year we designed, on request of the American Medical Association for their Annual Meeting in Cleveland, a model Cancer Detection Clinc. Tele-

*See Louis G. Dublin, *After Eighty Years*, pp. 173, 175 Univer. of Florida Press, 1966.

vision gave us a new outlet for our health message, first used on Station WEWS in 1948. On a statewide scale "Prescription for Living," sponsored by Standard Oil of Ohio and operated jointly with the Academy of Medicine, had an average of three quarters of a million viewers on 68 Sunday afternoons during the winter months of 1953-1955.

Pleasant Surprises

As in everybody's personal life and in the affairs of any business we too had our ups and downs. Sins of commission and omission I will leave to the Recording Angel to be concerned with. Some of my friends had often urged me to broaden the basis of the Cleveland Health Museum so that it could take on projects on a more national scale. Without planning to do so, the museum more or less grew into such a position. The surprise was that not only a dozen health museums per se were patterned after the Cleveland model, but that science museums, historical societies, and best of all, hospitals such as the Lankenau Hospital and the Reading Hospital in Pennsylvania and the Hertzler Clinic in Halstead, Kansas, added permanent health exhibits to their other educational facilities. The Kettering Family sponsored the first health museum located in a medical office building in Hinsdale, Illinois.

Our workshops have provided, and still do, copies of exhibits all over the United States including Hawaii (Bishop Museum) and foreign countries such as the Science Museum in London and the Phillips Company in Holland.

Honors have come my way with my retirement in 1965—the Elisabeth S. Prentiss Award which I had originated in 1944 as the first one in the field of Health Education—somewhat to the envy of my friends in the American Medical Association. I was surprised and flattered to follow George Szell of the Cleveland Orchestra in being selected the 1967 recipient of the Golden Door Award[8] established by the American Council for Nationalities Service to honor Americans of foreign birth who have made distinguished contributions to American life and culture.

International Work

It was natural that with my European upbringing and my professional background, I kept busy in the field of international relations. I attended as a private observer the constituting first assembly of the World Health Organization in Geneva in 1948. With the help of Dr. James A. Doull, a board member of the museum and then director of the International Division of the U. S. Public Health Service, I prepared a resolution which was presented and adopted "to establish in the secretariat a section on Public Health Education." This resolution was introduced by Dr. Jose P. Bantung, the delegate of the Philippines, who had just finished a three-month internship at the Cleveland Health Museum.[9] I was one of the cofounders of the International Council of Museums and quite active in the Museums Section of UNESCO. I was therefore more than pleased that in a message from the President of the United States this was recognized, to wit:

Dear Dr. Gebhard,

This country can be proud of the example the Cleveland Health Museum has set around the world. Established as the first institution of its type in this hemisphere, the Health Museum, under your direction, has become a world wide standard in Public Health education. My congratulations and best wishes on your retirement.

Lyndon B. Johnson
Washington, D C., June third 1965.

Epilogue

This story was written first in German as an answer to a double question often posed to me: "Why did you leave Germany?" and "What were your guiding lines in developing the Cleveland Health Museum?" One of these questioners was Prof. Karl E. Rotschuh, Director of the Institute for the History of Medicine, University of Muenster, Germany and editor of *Hippokrates*. My reply appeared in that journal as No. 21 in a series *Aerzte unserer Zeit in Selbstdarstellungen* with the title *Vom Sozialhygieniker zum Health Educator*. (Hippokrates, 38, 5, p. 200 to 206, 1967 Stuttgart.)

I am not a day-by-day diarist but I am a scrapper as was Henry E. Sigerist who wrote: "There are two types of men, scrappers and non-scrappers. Cushing is a scrapper and so am I. All historically minded people are."[10] A chronological history of the Cleveland Health Museum is to be found in its 27 annual scrapbooks.

Readers who know me personally might judge by themselves how far I have succeeded in facing the real problem of any memoir writer "to avoid subtle and secretive self-justification, especially when one is recording discarded emotions and beliefs."[11]

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Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

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Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

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Diabetogenic Effects of Nicotinic Acid

Case Reports and Discussions

RAY C. JANOVSKY, M.D.

IMPAIRED GLUCOSE TOLERANCE associated with prolonged administration of large doses of nicotinic acid has been reported previously,[1-5] but renewed interest in the drug in the field of cardiology,[6] and continued interest among some groups in psychiatry[7-9] may expose many diabetics to a prolonged, and possibly fruitless search for the etiology of diabetic ketosis.

Extensive discussion with usually well-informed physicians, including those with special interest in diabetes, would indicate little awareness of the diabetogenic effects of nicotinic acid. Our suspicion was first aroused when two relatively stable diabetics simultaneously developed diabetic ketosis while receiving nicotinic acid therapy for a psychiatric disorder. None of the usual precursors for aggravation of diabetes could be demonstrated.

Report of Cases

Case No. 1: The patient, a 62 year old white female, had 14 separate St. Luke's Hospital admissions between 1958 and 1966 because of schizophrenia associated with an agitated depression. In 1963 a slightly elevated fasting blood sugar (114 mg./100 cc.)* prompted a glucose tolerance test. The fasting blood sugar was 114 mg./100 cc.; 1 hour 234 mg./100 cc.; 2 hour 142 mg./100 cc.; and 3 hour 86 mg./100 cc. The patient was not obese (weight 123 lbs.), and no specific diabetic therapy was instituted at that time. On June 6, 1966, after countless other therapeutic measures had provided only transient benefit, she was started on nicotinic acid because of schizophrenia. The fasting blood sugar on this admission was 116 mg./100 cc. There was apparent improvement in the psychiatric problem and she was discharged on June 24, 1966 on a maintenance dose of 1.0 gm. of nicotinic acid four times daily.

She was readmitted to St. Luke's Hospital on September 26, 1966. Except for the recurrent psychiatric problem, the only complaint was weight loss (weight 105 lbs.) and nocturia (10 to 12 times). A thorough physical examination was not remarkable.

The admissions laboratory examinations revealed a hemoglobin concentration of 14 gm./100 cc.; hematocrit 43 per cent; white blood cell count (WBC) 6,500 per cu. mm., with 57 per cent segmented neutrophils, 2 per cent band cells, 29 per cent lymphocytes, 7 per cent eosinophils, and 5 per cent monocytes. The urine showed a specific gravity of 1.036 with a pH of 5.5, urine protein and microscopic examination were negative, but the test for glucose was 4 per cent (8 plus) and acetone was positive. The fasting blood sugar was 299 mg./100 cc.; blood urea nitrogen (BUN) 4 mg./100 cc., carbon dioxide 21 mEq/liter, serum sodium content 144 mEq/liter, serum potassium content 3.7 mEq/liter, and serum chloride 93 mEq/liter. The serologic test for syphilis (VDRL) was negative. A urine culture showed no growth. A chest film was normal. Two protein-bound iodine determinations on previous admissions had been normal.

She remained afebrile and repeated search for sites of infection was not successful.

The Author

● **Dr. Janovsky, Cleveland, is Senior Associate Physician and Head of Hypertension Renal Clinic, St. Luke's Hospital.**

* AutoAnalyzer

From the Division of Medicine, St. Luke's Hospital, Cleveland, Ohio. Submitted February 2, 1968.

She was started on a diabetic diet and regular insulin and later NPH insulin was substituted. The doses were gradually increased (Table 1) and eventually the blood sugars reached acceptable levels, but over a period of more than four weeks the fractional urines continued to show large amounts of glucose and acetone on one or more specimens daily. On October 31, 1966 (26 days after institution of diabetic therapy), the fasting blood sugar was 128 mg./100 cc., but the carbon dioxide content was 15 mEq/liter and the plasma acetone was slightly positive. A venous blood pH was 7.35.

At this point evaluation of the patient's entire hospital record was attempted, and aggravation of the diabetes seemed to coincide with institution of nicotinic acid therapy. Review of the literature at this time[1-5] revealed that nicotinic acid might have a diabetogenic action, and it was discontinued on October 31, 1966. Within 72 hours the urine was free of glucose and acetone and the plasma carbon dioxide content had increased to 27 mEq/liter. The insulin was gradually decreased, and finally discontinued ten days after nicotinic acid therapy was stopped. The blood sugars on November 10, 1966 were 146 mg./100 cc (fasting), 132 mg./100 cc. (11:00 A. M.), and 169 mg./100cc. (4:00 P. M.).

Case No. 2: The patient, a 60 year old white female, was first discovered to have diabetes at age 30. She was controlled with an average dose of 25 units NPH insulin daily.

She was admitted to St. Luke's Hospital in 1953 (at age 47) for regulation of diabetes and had three subsequent admissions for minor surgery. The dose of insulin remained constant.

In 1964 she received electroshock therapy at the Cleveland Clinic because of depression. In 1965 she was admitted to St. Luke's Hospital in a comatose state after ingestion of 27 grains of barbiturates. Recovery was uneventful. On March 13, 1966 she was admitted because of recurrent involutional psychotic reaction, otitis externa and cellulitis of the face. *Staphylococcus aureus* was cultured from the ear. She was treated with sodium oxacillin and local measures. Despite the infection, the diabetes was not a problem.

She was readmitted to the psychiatric service of St. Luke's Hospital on August 31, 1966. The history and physical examination, except for the psychiatric problem, were noncontributory. The admission laboratory data revealed a WBC of 9,000 per cu. mm., hemoglobin of 12.7 gm./100 cc., and hematocrit 37 per cent. The urine showed a specific gravity of 1.010 with a pH of 6.0, the urine protein, glucose, and microscopic examination were negative. The fasting blood sugar was 108 mg./100 cc., BUN 13 mg./100 cc., serum cholesterol 268 mg./100 cc., serum glutamic oxaloacetic transaminase (SGOT) 14 units. Except for remote inflammatory disease at the left base, a chest film was not remarkable. Approximately one half of the fractional urines were positive for glucose, but acetone free. Therapy included a diabetic diet (180 gm. carbohydrate; 80 gm. Protein; 80 gm. Fat), NPH insulin (25 units), electroshock, and at various times, psychotropic drugs including Compazine® (prochlorperazine), Stelazine® (trifluoperazine hydrochloride), and Parnate® (tranylcypromine sulfate).

On September 9, 1966, nicotinic acid was added and gradually increased to 1.0 gm. three times a day. On September 13, 1966, the fractional urines all became positive for glucose and strongly positive for acetone. On September 30, the fasting blood sugar was 372 mg./100 cc. and the carbon dioxide content was 22 mEq/liter. The insulin was gradually increased to 60 units (Table 2), but for more than seven weeks the blood sugar remained markedly elevated, and fractional urines contained large quantities of glucose and acetone on virtually every specimen. A 24-hour urine contained 104 grams of glucose.

A careful reevaluation of the patient failed to disclose the reason for the sudden aggravation of the diabetes.

TABLE 1. *Aggravation of Diabetes with Nicotinic Acid Therapy — Case No. 1*

Date	Fasting Blood Sugar-mg./100cc.	Carbon Dioxide Content-mEq/liter	Daily Insulin Dose—(units)
9-27-58	62		0
8- 7-61	96		0
4-12-63	114		0
4-18-64	100		0
* 6- 7-66	116		0
10- 5-66	299	21	25
10- 6-66	358	26	35
10- 7-66	170		30
10- 8-66	290		30
10-13-66	228	19	15
10-15-66	190		25
10-16-66	167	17	30
10-20-66	150	20	15
10-26-66	178		15
10-28-66	128	17	40
**10-31-66	255	15	30
11- 3-66	168	27	25
11- 7-66	140		15
11-10-66	146		0
11-11-66	131		0
6- 8-67	120	28	0
6-10-67	110		0

* Date nicotinic acid therapy started
** Date nicotinic acid therapy stopped

TABLE 2. *Aggravation of Diabetes with Nicotinic Acid Therapy — Case No. 2*

Date	Fasting Blood Sugar-mg./100cc.	Carbon Dioxide Content-mEq/liter	Daily Insulin Dose—(units)
12-30-51	57	29	30
11-28-56	76		25
7-12-58	70		25
9- 6-62	81		25
4-30-66	78	31	25
5- 3-66	60		25
5- 6-66	58		25
8-31-66	108		25
9- 1-66	108		25
* 9- 9-66			25
9-30-66	372	22	25
10- 1-66	372	22	25
10- 7-66	332		35
10- 9-66			45
10-11-66			50
10-15-66			55
10-17-66	304		60
**10-31-66	278	22	25
11-25-66	209 (2 Hr. p.c.)		25
1- 3-67	340 (2 Hr. p.c.)		25
3- 3-67	65 (2 Hr. p.c.)		22
3-24-67	98 (2 Hr. p.c.)		18
4- 7-67	113 (2 Hr. p.c.)		18

* Date nicotinic acid therapy started
** Date nicotinic acid therapy stopped

She remained afebrile and a repeat WBC was 5,000 per cu. mm. A bromsuphalein test showed 8 per cent retention. Skull films showed a normal sella turcia.

On October 19, 1966, suspecting the possibility of rebound from excessive insulin, the dose was cut in half for a period of five days and then cut in half again. There was no demonstrable improvement.

On October 28, 1966 the possibility of insulin antibodies was considered and pork insulin was substituted, again with no improvement.

As the diabetes showed no signs of ameliorating, all of the psychotropic drugs except for nicotinic acid were discontinued. The diabetic ketosis persisted. It finally became apparent that this patient, and the one previously described were behaving in a similar bizarre fashion. On October 31, 1966 nicotinic acid therapy was stopped on both patients.

Within 48 hours acetonuria had cleared, and she was discharged on November 3, 1966 on a dose of 25 units NPH insulin. Blood and urine sugars showed continued improvement, and a 2-hour postprandial blood sugar on April 7, 1967 was 113 mg./100 cc. while a 24-hour urine showed only 440 mg. of glucose. In the four months following cessation of nicotinic acid therapy her weight increased from 108 to 121 lbs. and insulin requirements dropped to 18 units NPH per day.

Discussion

Until recently the only established use for nicotinic acid was in the treatment of pellagra and possibly in the encephalopathic syndrome of chronic alcoholics. It has been used as a vasodilator to improve the blood flow in the cerebral and coronary circulation, but supportive evidence of its efficacy is lacking.

Currently the United States Public Health Service is carrying out a cooperative study on a nationwide basis (The Coronary Drug Project)[6] to explore the effect of four cholesterol reducing drugs in preventing recurrence of myocardial infarction. These drugs were selected on the basis of demonstrated cholesterol reducing ability, and include nicotinic acid; conjugated equine estrogens (Premarin®); dextro-thyroxine (Choloxin®); and ethyl-chlorophenoxy-isobutyrate (clofibrate, CPIB,® Atromid-S®). Each patient will receive one drug on a double-blind basis throughout five years of the study, and the group will eventually total more than 8,000 patients.

The use of nicotinic acid in schizophrenia has been a controversial subject for many years, and its final evaluation is not complete.[7-12] Schizophrenia continues to be a ubiquitous disease, however, and therapy continues to be an enigma. Under these circumstances the empiric use of nicotinic acid in a fair number of schizophrenic patients seems highly probable.

Most of the side effects of large doses of nicotinic acid are well known, and to some extent limit its usefulness. These side effects include flushing, pruritus, dryness of the skin, anorexia, nausea, vomiting and diarrhea. In a significant minority laboratory evidence of liver dysfunction has been reported, but was accompanied by hepatocellular change in only a few cases.[1,2] Hyperuricemia, and rarely, gouty arthritis have been observed.[1]

Less well known, but potentially more troubesome from the standpoint of differential diagnosis, are the diabetogenic effects of large doses of nicotinic acid.

TABLE 3. *Summary of Data Before, During, and After Nicotinic Acid Therapy**

Case No. 1	Before	During	After
Daily insulin dose, units	0 [8 years]	26 [25 days]	0 [180 days]
Fasting glucose mg. per 100 cc.	97.6 (5)	219 (11)	135 (5)
Case No. 2			
Daily, insulin dose, units	25 [15 years]	42 [18 days]**	21 [158 days]†
Fasting glucose mg. per 100 cc.	75 (9)	331 (5)	165 (5)

* Fasting glucose shown as means with number of determinations indicated in parenthesis. ( )

** Period from October 1 to 18 considered as more nearly representative of insulin requirements while on nicotinic acid. After this date the insulin dose was cut in half on the assumption that the patient was experiencing a rebound from excessive insulin.

† Period of observation indicated in brackets. [ ]

In the few reports available on the subject there seems to be agreement that nicotinic acid, if given over long periods of time in large doses, causes a variable, but consistent decrease in carbohydrate tolerance in both normal and diabetic subjects.[1-5] The exact mechanism of diabetogenic effect is not clear, but it has been suggested that it is related to impaired utilization of carbohydrate.[5]

Initially it was felt that the management of adult-onset diabetes mellitus was little effected by such therapy, and in no instance was permanent interruption of nicotinic acid felt to be necessary.[2,3] Molnar,[5] working with six diabetic volunteers showed aggravation of the diabetic process in all subjects after large doses for prolonged periods. This was characterized by increased glycemia and glycosuria as well as by elevated concentrations of serum ketone bodies and free fatty acids. Glycemia and glycosuria could be kept near pretreatment levels by increasing the dose of insulin or oral hypoglycemic drugs, but even when such an increase in dosage was made, blood levels of ketone bodies and free fatty acids remained elevated. The effects of nicotinic acid were promptly reversible when administration of the agent was stopped.

Our experience in these two cases of adult-onset would indicate that the diabetes was definitely made worse by large doses of nicotinic acid administered over a long period of time (Table 3). Marked glycosuria and acetonuria appeared as early as 72 hours after institution of therapy. In one patient hyperglycemia could be controlled by increasing the dose of insulin, but weight loss and ketosis continued to be a problem in both.

From the study of these two patients, we would have to conclude that nicotinic acid administered under the conditions described has a diabetogenic effect. It can produce an aggravation of adult-onset diabetes of sufficient severity to require interruption of therapy, but the effects are promptly reversible when the drug is discontinued.

Summary

Two patients with adult-onset diabetes were treated for prolonged periods of time with large doses of nicotinic acid because of psychiatric disorders. In both there was aggravation of the diabetes with development of diabetic ketosis. Interruption of nicotinic acid therapy resulted in prompt return of diabetic control to pretreatment levels. Current interest in the drug may expose countless diabetics to its diabetogenic effects. Unless the physician is alert to the problem, prolonged search may be necessary to establish the etiology of diabetic ketosis in patients so treated.

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Arterial Trauma

A Review of 88 Acute Injuries

NEIL R. THOMFORD, M.D., and SAMUEL A. MARABLE, M.D.

NECESSARY methods and materials exist for the repair of injuries to large arteries of the neck, trunk, and extremities. Thus, when acute arterial trauma is not immediately followed by fatal hemorrhage, restoration of normal blood flow distal to the injury is technically possible. Unfortunately, delay in diagnosis or operation often results in permanent disability or death.[1-4]

The importance of primary repair of arterial injuries was established when the methods and results of management of vascular injuries during the Korean War were compared with those of World War II. Injuries of the popliteal artery treated by ligation during World War II were followed by an amputation rate of 73 per cent.[5] When similar injuries were managed by primary repair during the Korean War, the rate of amputation decreased to 32 per cent.[6,7] Subsequent studies developed satisfactory technics for reconstruction of major arterial channels and emphasized the need for early operation to avoid the complications associated with prolonged ischemia of an organ or extremity.[1-4]

The present report is an appraisal of a series of acute arterial injuries. In addition to tabulating the etiologic factors, the anatomical types of vascular injury, and the results of management, injuries resulting in permanent disability or death have been studied in an effort to determine the major causes of failure.

Material

The case records of all arterial injuries managed at The Ohio State University Hospitals in the 15 year period from January 1, 1953 through December 31, 1967 were reviewed. Cases in this study include only injuries to major arteries which resulted in hemorrhage, ischemia, or other *early* complications. Cases of undetected injuries resulting in *late* complications managed during a subsequent hospitalization are excluded. Injuries of the digital arteries are also excluded. Within the scope of these criteria, 88 acute arterial injuries in 84 patients were recognized.

From the Department of Surgery, The Ohio State University College of Medicine, Columbus, Ohio. Submitted February 1, 1968.

The Authors

● Dr. Thomford, Columbus, is Assistant Professor, Department of Surgery, The Ohio State University College of Medicine.

● Dr. Marable, Columbus, is Assistant Professor of Surgery, The Ohio State University College of Medicine; a member of the Staff in General and Thoracic Surgery, University Hospital; and the Associate Staff, Children's Hospital; Consultant in Surgery, The Ohio Tuberculosis Hospital, Columbus; and Consultant in Surgery, Veterans Administration Center, Dayton.

Findings

Sixty-three patients were male and 21 female; their ages ranged from 8 to 69 years. Nineteen of the 88 injuries were of the ulnar artery; the thoracic aorta, brachial, radial, and superficial femoral arteries were each injured eight times (Table 1). The common carotid, anterior tibial, and posterior tibial arteries were each injured four times, and the subclavian artery, abdominal aorta, renal artery, and common iliac artery were each injured three times. The superficial temporal, axillary, superior mesenteric, external iliac, and popliteal arteries were each injured twice, while the internal mammary, gastroepoploic, and inferior mesenteric arteries each sustained a single injury.

Sixty-two injuries resulted from penetrating trauma, and 26 were caused by blunt insults. All injuries of the thoracic aorta, mesenteric arteries, and popliteal artery resulted from blunt trauma. Eighty of the 88 arterial injuries consisted of one or more of the wall of the vessel or transection of the artery. In the remaining eight cases, the adventitia of the damaged vessel was intact, and the injury was described as fracture of the intima with intramural hematoma and occlusion of the lumen by thrombus.

Eleven of the 88 injuries were iatrogenic. These injuries included damage of a superficial femoral artery during operation for osteomyelitis of the femur,

laceration of a common iliac artery when removing a herniated intervertebral disc, injury of an external iliac artery during the insertion of an arterial cannula via the femoral artery, injury of a subclavian artery during a technically difficult operation to remove the upper lobe of the right lung, laceration of a subclavian artery during biopsy of the first rib, and laceration of a renal artery during an attempt to obtain a percutaneous needle biopsy of the kidney. Five of the iatrogenic injuries occurred during attempts to perform arteriography; one each of the axillary and superficial femoral artery, and three of the common carotid artery.

The most common manifestation of arterial injury was local hemorrhage, the major finding in 74 cases. Physical examination suggested the arterial injury when there was external bleeding from an open wound, a pulsatile hematoma, or classical findings of hemothorax or hemoperitoneum. Hemorrhage into the mediastinum or retroperitoneum was established by plain roentgenograms or arteriography. Ischemia of a part of the body to which the injured artery normally supplied blood was the primary finding in 14 of the 88 injuries. With the exception of an ischemic kidney from thrombosis of a renal artery, the ischemic part was one or more extremities.

Fourteen (17 per cent) of the 84 patients died. The arterial injury was the principal cause of death in 11 cases.

TABLE 1. *Distribution of 88 Acute Arterial Injuries*

Artery Injured	No. Injuries
Thoracic Aorta	8
Common Carotid	4
Superficial Temporal	2
Subclavian	3
Internal Mammary	1
Axillary	2
Brachial	8
Radial	8
Ulnar	19
Abdominal Aorta	3
Gastro-epiploic	1
Superior Mesenteric (Major Branch)	2
Renal	3
Inferior Mesenteric	1
Common Iliac	3
External Iliac	2
Superficial Femoral	8
Popliteal	2
Anterior Tibial	4
Posterior Tibial	4
Total	88

Thoracic Aorta

All eight patients were injured in automobile accidents. Several of these cases, including the first successful repair of a traumatic rupture of the isthmus of the thoracic aorta,[8] have previously been reported.[9] Four of the eight patients were transferred from another hospital; the time intervals from injury to admission at The Ohio State University Hospitals were six hours and 2, 8, and 9 days. The periods of time from injury to admission for the remaining four patients were 2, 3, 3½, and 8 hours. Three patients had marked hypertension in the upper extremities with diminished or absent pulses in the lower extremities. Two patients were hypotensive, and in the remaining three cases the blood pressure was normal. Without exception, the chest x-ray of each patient showed widening of the mediastinum and a pleural effusion on the left side. Five of the eight patients had associated severe injuries to other areas of the body, which included at least one fracture of bone. Aortography, performed in three of the eight cases, showed extravasation of dye at the site of the aortic laceration. Seven patients underwent an operation to repair the aortic laceration; the remaining patient died suddenly five hours after admission to the hospital. The period of time from admission to the hospital to thoracotomy varied from 1 to 7 hours, with the exception of 15 hours for a single case in which an emergency abdominal operation was necessary for hemorrhage from lacerations of the liver and spleen. In all instances, the laceration of the aorta was located adjacent to the left subclavian artery but distal to its origin. The extent of the laceration varied from 4 mm. to rupture of more than 50 per cent of the circumference of the aorta in four patients. In two patients, the aorta was repaired with sutures and reinforced with a Teflon™ patch; one patient survived. Resection of the damaged segment of aorta and end-to-end anastomosis in two patients was followed by recovery in one case. Operations in three cases consisted of resection of the damaged segment of aorta replacement with a Dacron™ graft; two patients died during the operation and the third died from hemorrhage in the early postoperative period.

Common Carotid and and Superficial Temporal Arteries

Two of three injuries of the common carotid artery caused by attempts to perform arteriography were repaired by suture, and the third was managed by ligation of the vessel; all three patients recovered without permanent effects attributable to their arterial injury. The fourth injury of the common carotid artery, transection by a knife, was treated by ligation of the common carotid artery, and the patient recovered without any vascular sequelae. The two injuries of the superficial temporal artery were managed by ligation of the vessel, and there were no complications.

Subclavian, Internal Mammary, Axillary, Brachial, Radial, and Ulnar Arteries

The three injuries of the subclavian artery were all managed by ligation; in two instances the first portion of the vessel was ligated, and one injury was treated by ligation of the third portion of this artery. There were no vascular sequelae, but hemorrhage from the

injured vessel was the major cause of death in one of two patients who died. The single injury of the internal mammary was managed by ligation of this vessel.

Replacement of a destroyed segment of an axillary artery with an autograft from the superficial femoral vein resulted in recovery of normal motor function and sensation in the injured extremity. The only other injury of an axillary artery, laceration during percutaneous transaxillary arteriography, was followed by the insidious onset of median nerve dysfunction distal to the injury. Five days after the injury, a periarterial hematoma was evacuated and lacerations of the artery were sutured. Minimal but permanent weakness of muscles of the hand supplied by the median nerve persisted after the operation.

Seven of eight brachial artery injuries were repaired. In six cases, normal blood flow was restored; five operations consisted of debridement and end-to-end anastomosis of the artery, and in one case a destroyed segment of the brachial artery was replaced with a venous autograft. Failure to permanently restore normal blood flow in the seventh patient resulted when operation to repair a relatively large defect in the arterial wall was limited to closure of the defect with sutures. The remaining patient with a brachial artery injury did not seek medical aid until two weeks after a severe laceration and contusion of the mid-portion of the upper arm. Arteriography demonstrated occlusion of the brachial artery. The radial pulse was palpable and the blood supply to the distal limb was adequate. Exploration of the brachial artery was not advised because of an open wound at the site of injury. In no instance was injury of a brachial artery followed by permanent disability which could be attributed to the vascular injury.

There were nineteen injuries of the ulnar artery; five cases were managed by end-to-end anastomosis of the severed vessel, and in fourteen cases the artery was ligated. The radial artery was injured six times; one injury was repaired by an end-to-end anastomosis, and in five cases the artery was ligated. In no instance was an injury of the radial or ulnar artery followed by significant ischemia of the hand, including a single case in which concomitant injuries of the radial and ulnar arteries at the right wrist were managed by ligation of both vessels.

Abdominal Aorta, Gastroepiploic, Superior Mesenteric, Renal, and Inferior Mesenteric Arteries

Two injuries of the abdominal aorta were caused by bullet wounds. One patient continued to hemorrhage after his injury and died during an emergency operation. The second patient underwent an operation at another hospital within a few hours after injury. Defects in the duodenum and colon were repaired, and retroperitoneal hemorrhage was noted. He was transferred to The Ohio State University Hospitals nine days later because of an enlarging mass and a bruit in the epigastrium. Arteriography demonstrated a fistula between the aorta and the portal vein. Operation was performed within one hour, but an exsanguinating hemorrhage occurred during induction of anesthesia, and the patient died before bleeding from the injury of the aorta could be controlled. The third patient with an injury of the abdominal aorta was transferred to The Ohio State University Hospitals five days after being injured in an automobile accident. In addition to traumatic thrombosis of the abdominal aorta immediately distal to the origin of the inferior mesenteric artery and gangrene of the right foot, she had a rupture of the proximal jejunum with multiple abscesses within the peritoneal cavity. The jejunum was repaired, the abscesses drained, and the right lower extremity was amputated 5 inches distal to the knee joint. Six months later normal blood flow was restored by replacing the distal aorta and proximal common iliac arteries with a Dacron™ prosthesis.

The injuries of the gastroepiploic artery, inferior mesenteric artery, and major branches of the superior mesenteric artery were all managed by ligation of the damaged vessels.

Renal artery injuries included a laceration caused by an attempt at percutaneous needle biopsy of the kidney. At the time of the biopsy the patient had severe renal failure. He died four days later, and post mortem examination identified a retroperitoneal hematoma estimated to represent 1,500 cc. of whole blood. The loss of blood had been adequately replaced, and the arterial injury was not the cause of death. A second renal artery injury was caused by blunt trauma to the flank. Thrombosis of the renal artery was revealed by arteriography; intravenous and retrograde urograms showed a nonfunctioning kidney of normal size. No operation was performed, and the patient's recovery was uneventful. The final injury of the renal artery was caused by a bullet wound, which destroyed the artery and necessitated nephrectomy. Multiple injuries, a prolonged period of hypotension, and loss of one kidney resulted in death from acute renal failure.

Common Iliac, External Iliac, Superficial Femoral, and Popliteal Arteries

Injuries of these arteries present similar problems since they are frequently associated with skeletal trauma and often cause prolonged ischemia of the lower extremity, resulting in permanent impairment of its function or amputation (Table 2).

Seven of the 15 arterial injuries were caused by blunt trauma. In all seven there was an associated fracture of an adjacent bone. Four of the seven arterial injuries resulting from blunt trauma consisted of fracture of the intima, intramural hematoma, and

Table 2. *Injuries of the Iliac, Femoral, and Popliteal Arteries*

Case No.	Artery	Trauma	Injury	Associated Skeletal Injury	Physical Findings		Time Interval From Injury to Operation	Operation	Fasciotomy	Result
					Distal Pulses	Neurological				
1	Common Iliac	Blunt	Fracture of intima, thrombosis	Fractures of Pelvis	Absent	Flaccid, Anesthetic extremity	5 hours	Replaced with Dacron Prosthesis	No	Complete recovery
2	Common Iliac	Blunt	Fracture of intima, thrombosis	Fractures of Pelvis	Absent	Flaccid, Anesthetic extremity	11 hours	Cross-leg Dacron prosthesis (Femoral a. to femoral a.)	12 hours later	Blood flow restored but patient died of gas gangrene
3	Common Iliac	Penetrating	Laceration	None (Iatrogenic Injury)	Present	Undetermined (General Anesthesia)	15 minutes	Laceration sutured	No	Complete recovery
4	External Iliac	Blunt	Fracture of intima, thrombosis	Fractures of Pelvis	Absent	Flaccid, Anesthetic extremity	21 hours	Replaced with Dacron prosthesis	12 hours later	Blood flow restored. Permanent loss of motor function and sensation distal to knee
5	External Iliac	Penetrating	Laceration	None (Iatrogenic Injury)	Present	Undetermined (General Anesthesia)	1 hour	Laceration sutured	No	No sequelae from vascular injury, patient died from other causes
6	Superficial Femoral	Blunt	Laceration	Fracture of Femur	Absent	Anesthesia of foot, no motor function of leg	7 hours	End-to-end anastomosis	No	Blood flow restored. Permanent loss of motor function distal to knee
7	Superficial Femoral	Blunt	Transection	Fracture of Femur & Tibia	Absent	Anesthesia of foot, no motor function of leg	7 hours	End-to-end anastomosis	10 hours later	Blood flow restored. Chronic osteomyelitis of femur, permanent loss of motor function distal to knee
8	Superficial Femoral	Penetrating	Laceration	———	Present	Normal	5½ hours	End-to-end anastomosis	No	Complete recovery
9	Superficial Femoral	Penetrating	Laceration	———	Absent	Normal	2½ hours	End-to-end anastomosis	No	Complete recovery
10	Superficial Femoral	Penetrating	Transection	Fracture of Femur	Absent	Normal	3½ hours	Ligated	No	Complete recovery, marked atherosclerosis had essentially occluded vessel at site of injury
11	Superficial Femoral	Penetrating	Laceration	None (Iatrogenic Injury)	Present	Undetermined (General Anesthesia)	8 days	Laceration sutured	No	Complete recovery
12	Superficial Femoral	Penetrating	Laceration	———	Present	Normal	6 hours	Laceration sutured	No	Complete recovery
13	Superficial Femoral	Penetrating	Laceration	None (Iatrogenic Injury)	Absent	Undetermined (General Anesthesia)	30 minutes	End-to-end anastomosis	No	Complete recovery
14	Popliteal	Blunt	Fracture of intima, thrombosis	Fractures of Tibia	Absent	Undetermined	3½ hours	Replaced with Dacron prosthesis	No	Thrombosis graft, second operation also failed, extremity amputated through distal thigh
15	Popliteal	Blunt	Transection	Fracture of Tibia	Absent	Loss of sensation and motor function of leg	7 hours	End-to-end anastomosis	Concomitant	Blood flow restored. Necrosis of muscles of leg, extremity amputated through distal thigh

occlusion of the lumen by thrombus. Laceration or transection of the artery occurred in 11 cases; pulses were palpable in the distal extremity in 5 of the 11.

The time interval from injury to operation for these 15 cases varied from 15 minutes to eight days. Lacerations and transections of arteries were managed by closure with sutures or debridement and end-to-end anastomosis with a single exception (Case 10) in which a markedly atherosclerotic superficial femoral artery was ligated. The four injuries in which there was fracture of the intima and intramural hematoma each required replacement or bypass of the damaged segment of the artery. Fasciotomies of the lower extremity were performed in four patients.

Eight of the patients recovered without any permanent disability which could be attributed to the vascular injury. In two cases amputation of a major portion of the extremity was necessary, and in three additional cases the function of the extremity was permanently impaired. In four of these five cases, restoration of blood flow to the distal extremity was accomplished, but the time intervals from injury to operation were 7, 7, 7, and 21 hours. Death in two remaining cases prevented adequate assessment of the results of arterial reconstruction.

Anterior and Posterior Tibial Arteries

Three cases of laceration of the anterior tibial artery and two of the posterior tibial artery were managed by ligation without vascular sequelae. Additional injuries of the tibial arteries included one case in which transection of the posterior tibial artery was repaired and one case in which both the anterior tibial and posterior tibial artery were transected but only the posterior tibial artery was repaired; in both cases associated fractures and extensive soft tissue damage resulted in amputation.

Discussion

Loss of life or limb from injury to a major artery is most often the result of failure to suspect or recognize the presence of an arterial injury. Rupture of a large artery may be followed by temporary cessation of hemorrhage for a period of hours or days and then sudden death from recurrent bleeding. In the present series, this course of events was most common with injuries of the thoracic aorta when diagnostic procedures or operation were delayed. A pulsatile hematoma or acute arterial insufficiency of an extremity following damage of a major artery is frequently overlooked in cases of multiple, severe injuries.[3] When examining a patient who is hypotensive and semiconscious, the finding of a pale, cold, and pulseless extremity may not suggest an arterial injury, and adequate evaluation of the sensation and function of the limb is often not possible. Anesthesia of the skin of the distal limb, a reliable sign of arterial insufficiency,[3,10] is difficult to interpret in some cases of trauma since there may be associated direct damage of nerves. In other instances, arterial insufficiency from interruption or thrombosis of an artery is mistakenly attributed to temporary pressure on the artery fracture fragments or transient spasm of the arterial tree as a result of irritation of the external surface of the vessel.[11]

Arteriography is not essential for the diagnosis of all arterial injuries, but it is generally accepted as a useful aid in the evaluation of selected patients.[3] The value of arteriography has been demonstrated in cases in which a puncture wound is adjacent to a major artery,[12] arterial insufficiency of the distal limb may be the result of arteriosclerosis,[13] or injury of a major artery is questionable in a patient who has multiple, severe injuries.[14] Routine arteriography has been suggested for all cases in which there is a fracture of the femur.[15] If the need for operation and the site of the arterial injury are apparent, however, arteriography may delay the repair without providing significant information.

Indications for operation in cases of suspected injury to a major artery include active hemorrhage, a pulsatile hematoma, an open fracture, and acute arterial insufficiency which persists after closed reduction of the fracture. The decision to perform an operation is more difficult in cases where there is a mediastinal hematoma, questionable evidence of arterial insufficiency of a limb, or slow enlargement of a hematoma. If arteriography is unavailable or does not provide the necessary information, operation to explore the artery should be undertaken promptly unless associated injuries prevent surgical intervention.[3] A palpable pulse in the distal portion of an extremity and failure of dye to extravasate when arteriography is performed are not inconsistent with laceration of a major artery.[4] Although delay in the repair of arterial injuries is of relative rather than absolute significance,[14] observations in humans[3] and experiments in dogs[16] suggest that failure to restore arterial blood flow within four to six hours after injury frequently results in permanent damage to the extremity.

Established principles which are essential for the successful repair of arterial injuries include adequate debridement of the injured artery, removal of thrombus from the distal arterial tree, and preservation of all major collateral arterial channels.[3] Repair of localized arterial injuries by debridement and end-to-end anastomosis provides the best opportunity for permanent restoration of normal arterial flow. In isolated instances, however, fracture of the intima may be successfuly managed by a limited endarterectomy.[11] Replacement of a damaged segment of an artery is most often successful when a venous autograft is utilized,[17,18] since they are remarkably tolerant to turbulence of flow and infection.[19] Segments of vein, obtained from an uninjured extremity and equal in diameter to two thirds the diameter of the

injured artery,[18] may be used either as a direct replacement for the injured segment of the artery or, in selected open wounds, the graft may be placed in clean tissue and serve as a bypass.[15] Reconstruction of arterial channels with venous grafts is advisably limited to arteries with a diameter equal to or smaller than the common femoral artery, since replacement of larger arteries is often followed by aneurysmal dilatation of the graft.[18] Fasciotomy of the anterior tibial compartment and the calf should be combined with repair of most injuries to arteries which supply blood to the extremities.[4]

When an operation is performed to correct an injury of a major artery associated with fracture of the femur, it is important in most instances to immobilize the fracture fragments before attempting arterial reconstruction.[20,21] If internal fixation is indicated, satisfactory stabilization of fractures of the femur may be accomplished by inserting an intramedullary rod or reducing fracture fragments with slotted plates attached with screws.

Permanent impairment of function is not uncommon after arterial injuries of the upper extremity, but amputation is rarely necessary unless there is severe destruction of bone and soft tissues. Injuries of the iliac arteries or arteries of the lower extremity, however, are associated with a high incidence of amputation.[3,11] Although only two of our fifteen patients required an amputation, the function of the lower extremity was permanently impaired in three additional cases. Mortality rates for large series of civilian arterial injuries range from 8 to 15 per cent.[4,1] A comparison of mortality figures, however, is without value unless the relative incidence of each type of injury is the same for each series being studied.

Summary

Eighty-eight arterial injuries in 84 patients are described. In most instances, loss of life or loss of limb following an arterial injury could be attributed to failure to suspect or recognize the presence of damage to a major artery. Six of 14 deaths followed traumatic rupture of the thoracic aorta. Immediate evaluation of mediastinal hematomas by aortography is essential to avoid these catastrophies. Fifteen injuries of the iliac, femoral, and popliteal arteries resulted in death in two cases, amputation in two cases, and permanent damage to the lower extremity in three cases. A prolonged period of ischemia before operation was the principal cause of permanent disability. Arterial injuries resulting in interruption of blood flow to the lower extremity must be repaired within four to six hours to avoid irreversible ischemic changes.

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Intermittent Peritoneal Dialysis

DONALD G. VIDT, M.D.

INTERMITTENT peritoneal dialysis has enjoyed a notable increase in popularity during the last decade. Better understanding of complicated salt and water problems plus the availability of commercial dialysis solutions and disposable catheters has brought about general acceptance and wide usage of peritoneal dialysis in many medical centers. This report is based upon experience with 360 peritoneal dialyses performed during the last 24 months at the Cleveland Clinic Hospital.

The principle of the procedure is the utilization of a living semipermeable membrane, the peritoneum, which provides in excess of 20,000 sq. cm. of filtering area for the bidirectional diffusion of solutes and water along existing concentration gradients. A specific gain or loss of diffusible solute is achieved by adjusting the composition of the dialysis solution. Solutions with electrolyte concentrations similar to those of normal plasma are suitable in most clinical situations. The removal of water is controlled by raising or lowering the total osmotic concentration of the dialysis solution with a slowly absorbable substance, dextrose. Peritoneal dialysis is particularly suitable for the hospital in which no artificial kidney is available. Even in institutions in which the artificial kidney is available, peritoneal dialysis can be initiated quickly, with minimal preparation, without the need for heparinization or blood, and with fewer professional persons needed than are usually required for hemodialysis.

Methods

The same method of peritoneal dialysis was utilized in all patients. Routinely, before dialysis, the bladder was emptied by voiding or by catheterization, and sedation was given to the apprehensive patients. The preferred site for the incision was in the midline of the abdomen, about 2 cm. below the umbilicus. After the usual skin preparation, the skin and subcutaneous tissues were infiltrated with procaine hydrochloride down to the peritoneum. A small stab incision was then made in the skin with a No. 11 Bard-Parker™ blade. Although several types of disposable catheters are available, we prefer a No. 11 French semirigid plastic catheter, which was inserted through a specially designed metal trocar (Fig. 1). The trocar was advanced through the abdominal wall and through the peritoneum, after which the stylet was removed and the catheter was easily inserted into the most dependent portion of the abdominal cavity to a position to the right or to the left of the urinary bladder (Fig. 2). The catheter was fixed in place by a skin clip or purse-string suture to draw the skin tightly around the catheter. This minimized the possibility of leakage around the catheter. A dry dressing was taped firmly to the skin and the catheter was then taped to the dressing. This allowed relatively free movement of the patient in bed without fear of dislodging the dialysis catheter.

Two liters of dialyzing solution was then infused rapidly into the abdominal cavity and was allowed to remain for 30 minutes of equilibration. Table 1 lists the solute concentrations of the dialyzing solutions. Most exchanges were accomplished with a 1.5 per cent dextrose solution, a 7 per cent solution being combined with a 1.5 per cent solution only when it became desirable to increase the removal of water. The fluids were then drained into the same bottles that had been placed on the floor beside the bed. In this fashion, cycles were repeated at approximately one hour intervals. Most dialyses were continued for 24 cycles, occasionally 36 cycles, and rarely exceeded 48 cycles. Cultures were obtained from every eight cycles, and the patient was weighed after each eight cycles. Five milligrams of sodium heparin was added to each liter of dialysis solution, and usually from 3 to 4 mEq. of potassium chloride per liter. Prophylactic antibiotics, when added, consisted either of 20 mg. per liter of chloramphenicol, or 100 mg.

The Author

● Dr. Vidt, Cleveland, is Staff Member, Department of Hypertension and Renal Disease, Cleveland Clinic Foundation.

From the Department of Hypertension and Renal Disease, The Cleveland Clinic Foundation, Cleveland, Ohio. Submitted March 1, 1968.

per liter of tetracycline. When tetracycline was used, it was added only to the first two and the last two cycles of dialysis.

Results

Three hundred sixty dialyses were performed on 128 patients. Although most of the patients had chronic progressive renal failure and were undergoing evaluation for renal transplantation, other patients underwent dialysis because of acute renal failure, congestive heart failure, or refractory fluid retention, and several patients had intoxication from dialyzable poisons.

The efficiency of peritoneal dialysis has been estimated at 25 per cent of hemodialysis. Figure 3 shows the average reduction in blood urea and creatinine concentrations that occurred during consecutive cycles of peritoneal dialysis. Each complete cycle required approximately one hour, and therefore represented 2 liters of dialysate exchanged per hour. It is seen that the average blood urea concentration after 24 cycles of dialysis was approximately 55 per cent of the predialysis blood urea concentration, with a further reduction to 35 per cent of the predialysis concentration after 48 hours. The average reduction in blood creatinine concentration was predictably less than that obtained with urea because of the lower peritoneal clearance of creatinine.

Complications

Complications can be expected in any large series of dialyses. Table 2 lists the major complications noted in the series of patients. Bacterial peritonitis was the most important complication (36 patients), as in most series.[1,2] Change in character or color of fluid alone or a random positive culture was not sufficient to establish the diagnosis of peritonitis. All patients considered to have significant peritoneal infection had two or more positive cultures plus fever or abdominal tenderness. The offending organisms in 80 per cent of infections (29 of 36 patients) were the enteric pathogens, with *Escherichia coli* and *Aerobacter aerogenes* predominating in this group. There were five infections with coagulase-positive *Staphylococci,* and one each with *Streptococcus faecalis* and *Alpha (hemolytic) Streptococcus.*

Drainage problems were experienced in 34 instances. It is significant that dialysis had to be discontinued in only ten patients. In all others, drainage was reestablished by manipulation or re-

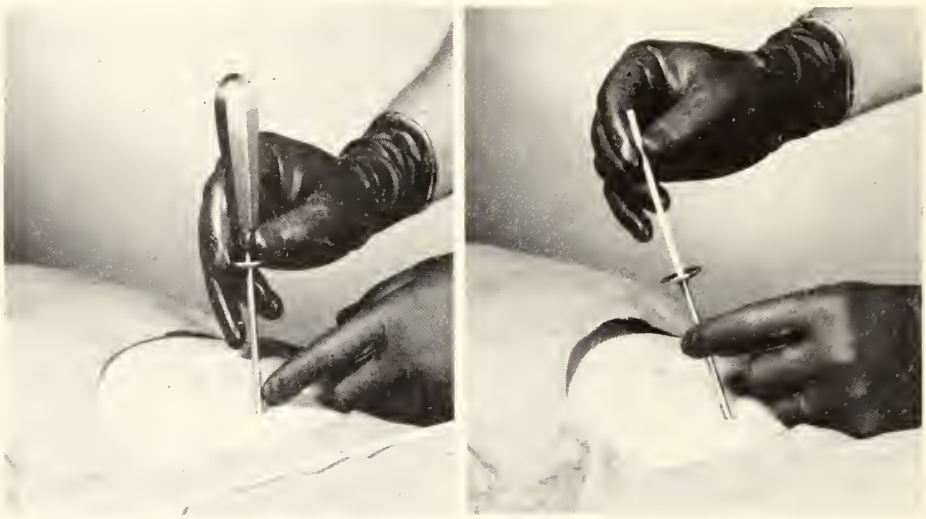


FIG. 1. *Peritoneal dialysis catheter inserted through a specially designed trocar.*

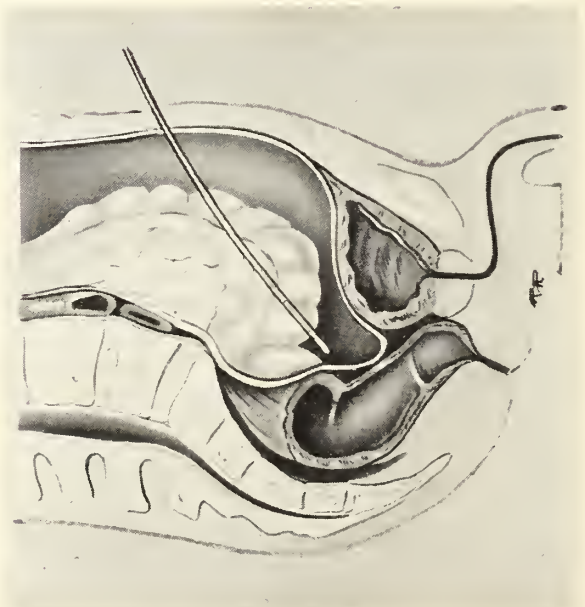


FIG. 2. *Desired placement of the catheter within the peritoneal cavity.*

TABLE 1. *Composition of Dialyzing Solutions*

Solute	Inpersol®* with Detrose 1.5%			Inpersol®* with Dextrose 7%		
	G/Liter	mEq/Liter	mOsm/Liter	G/Liter	mEq/Liter	mOsm/Liter
Sodium	3.23	140.5	140.5	3.23	140.5	140.5
Calcium	0.07	3.5	1.8	0.07	3.5	1.8
Magnesium	0.18	1.5	0.8	0.18	1.5	0.8
Chloride	3.58	101.0	101.0	3.56	101.0	101.0
Lactate	3.96	44.5	44.5	3.96	44.5	44.5
Dextrose	15	.....	83.3	70	.....	388.8
Total		291.0	371.9		291.0	677.4

* Inpersol® prepared by Abbott Laboratories. All available dialyzing solutions from several suppliers are quite similar in composition.

placement of the catheter. Bleeding occurred during 31 dialyses and consisted of hemorrhage into the fluids. Grossly bloody fluids cleared in most cases after several cycles, but occasionally persisted throughout the dialysis. However, bleeding was severe enough to require transfusion in only two patients.

The disequilibrium syndrome was noted in only five patients in this series. In four patients, somnolence and confusion were of brief duration and cleared within 24 hours after dialysis; one patient exhibited an overt psychosis that cleared spontaneously within several days.

Three patients, considered terminally ill before the start of the procedure, died shortly after dialysis was instituted. In one patient, acute peritonitis developed during dialysis, with subsequent sepsis and hypotension followed by cardiac arrest. He was resuscitated but died 72 hours later. Dyspnea, cyanosis, and hypotension suddenly developed in one patient three days after the completion of dialysis. Death in this instance most likely represented a pulmonary embolus, but autopsy was not performed.

Other minor complications were observed during dialysis, the incidences of which have not been listed, but they are worthy of brief mention. Superficial skin bleeding and leakage of fluids around the catheter occasionally occurred. Both problems were managed easily with the application either of skin clips or of purse-string sutures around the catheter. Abdominal discomfort in the absence of infection occasionally occurred during the early cycles, usually during the inflow of fluids. This discomfort could usually be relieved by repositioning the catheter or by slowing the rate of fluid infusion. Occasional complaints of discomfort after injection of the 2 liters of fluid most frequently were due to distension of the abdomen from the accumulation of fluid. This discomfort was eased by draining the excess fluid from the abdominal cavity during one or more subsequent drainage cycles. Orthostatic hypotension, occasionally occurring during the first 24 hours after dialysis, was related to large amounts of fluid removed during the procedure. When the symptom was severe, it was easily remedied by the intravenous infusion of from 1,000 to 1,500 ml. of normal saline.

Discussion

Peritoneal dialysis is a safe, effective procedure that can be performed any place where adequate nursing care is available. Since no special equipment is needed and since a graduate nurse or practical nurse can be easily trained to perform the procedure, peritoneal dialysis is particularly suited to use in the community hospital.

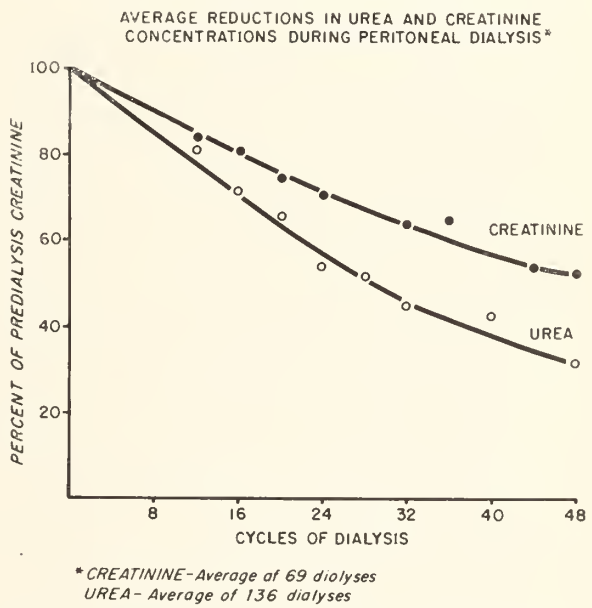


FIG. 3. *Graph showing reduction in blood urea and creatinine concentrations during consecutive cycles of peritoneal dialysis.*

Peritonitis, although the major complication, is easily managed with antibiotics. At the first sign of

infection, patients should be treated with systemic antibiotics as well as with antibiotics added to the dialysate. Infection is not an indication for terminating peritoneal dialysis. In fact, it has been my clinical impression that the peritonitis regressed quickly with continued dialysis, which allows immediate, adequate, antibiotic dosages at the site of infection. Continued dialysis appears to bring about rapid amelioration of abdominal discomfort, and I prefer to continue dialysis until the patient becomes symptom-free or until the dialysate becomes clear. Most patients are afebrile and otherwise free of symptoms within 24 to 48 hours after beginning therapy. The incidence of bacterial peritonitis can be markedly reduced by the prophylactic addition of antibiotics to the dialysate. No adverse effects from the use of tetracycline or chloramphenicol have occurred in the patients treated at the Cleveland Clinic; however, tetracycline has not been used throughout the dialysis, in view of reports[3, 4] of progressive accumulation of tetracycline in the serum of uremic patients.

All but one of the 36 instances of infection included in the present report occurred in patients who did not receive prophylactic chemotherapy. Prophylactic chemotherapy was used in 105 dialyses, with a resultant incidence of infection of less than 1 per cent in this group. This percentage compares favorably to an incidence of 13.7 per cent for the 255 dialyses performed without prophylactic chemotherapy. The predominance of gram-negative bacteria raises the question of transluminal spread of enteric bacteria into the peritoneal cavity. Schweinburg, Seligman, and Fine[5] showed that passive transmural migration of *Escherichia coli* occurs with prolonged chemical irritation of the intestinal serosa. A recent report[6] has suggested that bacterial peritonitis can be prevented by the oral administration of neomycin before and during dialysis.

Drainage problems are minimized by the addition of 5 mg. of sodium heparin to each liter of dialysate to inhibit the formation of fibrin or blood clots within the catheter. The occasional clot that forms despite the heparin can be dislodged by the metal stylet or guide wire packaged with the catheters. Inadequate drainage may also be due to an insufficient reservoir volume within the peritoneal cavity, omental blockage, displacement of the catheter, or to unkown causes. An additional 500 to 1,000 ml. of dialysate added to the drainage reservoir, or simple repositioning of the catheter will reestablish drainage in most instances. Otherwise the catheter will have to be removed and placed in a different location.

Peritoneal dialysis within 48 hours of abdominal laparotomy and bilateral nephrectomy has been accomplished without difficulty. Fluid loss through the abdominal incision has never presented a problem, and a tightly sutured peritoneum minimizes loss into the retroperitoneal space. Successful peritoneal dialysis after major abdominal or thoracic surgery has been reported by others.[7, 8]

Bleeding into the fluids is not uncommon, and often is associated with readily evident skin bleeding. As mentioned, both types of bleeding can be controlled by the placement of a deep purse-string suture around the catheter, probably because hemorrhage into the dialysis fluid results from bleeding along the catheter tract. Severe bleeding rarely occurs, since the midline abdominal site of catheter placement is free of major blood vessels. The incidence of bleeding has been reported to be further reduced by use of the stylet type of catheter.[9] My associates and I prefer the use of a trocar designed to accept freely a No. 11 French semirigid catheter. Once the trocar has been passed through the abdominal wall and the peritoneum, the catheter slides freely into the abdominal cavity. The slightest resistance from omentum or a viscus is readily felt, allowing redirection of the catheter. Perforation of the bladder or bowel has been reported to occur,[10, 11] but this complication was not experienced in the series of patients reported here. It has not been necessary to instill from 1 to 2 liters of dialysis fluid through a small-gauge needle before inserting the trocar. Preperitoneal placement of the catheter[2] has not been a problem in the patients of this report.

TABLE 2. *Complications During 360 Peritoneal Dialyses*

Complications	No. of cases
Peritonitis	36
Drainage problems	34
Bleeding into fluids	31
Disequilibrium syndrome	5
Death associated with dialysis	5
Other complications	
Leakage of fluids	
Skin bleeding	
Abdominal discomfort	
Orthostatic hypotension	

The disequilibrium syndrome occurs more often when overhydration and a high blood urea content are present at the beginning of dialysis. The blood urea concentration decreases more rapidly in the extracellular fluid than in the cerebrospinal fluid because of slower diffusion across the blood-brain barrier. The resultant osmotic gradient produces cerebral edema sufficient to cause symptoms of confusion, headache, nausea, and vomiting, or occasionally, convulsions and edema. The low incidence of these

symptoms in patients undergoing peritoneal dialysis is considered to be due to the slow rate of biochemical change.

All dialyses that are the basis of this report were performed by the regular nursing staff in an intensive medical care unit. No special precautions or protective isolation technics were employed. The catheter was always removed at the termination of dialysis, to minimize the possibilities of infection between dialyses. Most dialyses consisted of 24 exchanges (24 hours) and did not exceed 48 exchanges (approximately 48 hours). By limiting the duration of the procedure and encouraging the patient to be active in bed during dialysis, the incidence of pulmonary complications was not so high as that reported by Berlyne and colleagues.[12] Overhydration during dialysis was not a problem, as almost all patients lost weight during the procedure with 1.5 per cent dextrose as the basic exchanging solution. By minimizing the use of hypertonic solutions (4.25 per cent or 7 per cent dextrose), hypernatremia or hyperchloremia were avoided, and postdialysis hypotension from excessive fluid removal was a rare complication. Hyperglycemia is regularly noted during dialysis in patients with glucose intolerance.[1, 13] Symptoms suggestive of cellular dehydration or coma from high blood sugar concentrations have not been experienced, possibly because of the limited use of hypertonic solutions. Hypoproteinemic edema has not been noted in any of the patients during dialysis. Although significant protein losses occur during the course of peritoneal dialysis,[14] hypoproteinemia has presented a problem only in those patients undergoing repeated peritoneal dialyses over long periods. In addition, the protein loss is minimized by avoidance of hypertonic solutions.

Hypokalemia may occur when potassium-free dialysate is used for extended periods. The chief danger is the precipitation of digitalis toxicity, with potential fatal arrhythmias caused by rapid removal of potassium.[1] Care in dialyzing against potassium concentrations of from 2 to 4 mEq./liter added to all dialysis solutions has prevented severe arrhythmias. Potassium has been omitted from the dialysate only when the patient's serum potassium concentration is more than 6 mEq./liter, and then only for the first six to eight cycles.

Metabolic alkalosis has been reported[7] as having occurred late in peritoneal dialysis and is related to the relatively high lactate concentrations of commercially available dialysis solutions. The complication is avoided by limiting the duration of dialysis to 24 or even 48 exchanges, and when alkalosis occurs with longer dialysis, it does not usually require treatment. Lactic acidosis has been reported[15] to occur during peritoneal dialysis in patients with severe liver disease in whom lactate cannot be normally metabolized to bicarbonate, resulting in an uncorrected metabolic acidosis. This complication has not developed during any of the 360 peritoneal dialyses which are the basis of the present report. This complication remains a potential problem in patients undergoing dialysis for severe, hepatorenal disease.

Summary

Experience with 360 peritoneal dialyses is reviewed. The technic has proved simple, requires no special equipment, and can be performed by a trained nurse or paramedical person. The safety of the procedure, absence of serious complications, and its effectiveness make peritoneal dialysis suitable for use in any community hospital.

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Hemodialysis of a Severely Anemic Patient Without Added Blood

WARREN W. SMITH, M. D.

THIS IS A REPORT of hemodialysis of a patient with renal failure whose hemoglobin level was 5 Gm./100 ml., and who, for religious reasons, would not accept blood transfusion.

Report of Case

A 58 year old white male laborer was admitted to Riverside Methodist Hospital on June 29, 1967. His illness had begun several weeks previously with dizziness and weakness followed by bleeding from the gums, oliguria, and mental confusion. At the time of hospitalization, he was pale and acutely ill with dyspnea and mental confusion. There was clotted blood in both nostrils. Rales were heard over the lower portions of both lungs. Ascites and edema were not evident.

During the next 12 hours, the laboratory studies (certain of which are in the accompanying Table) revealed the presence of severe anemia and renal failure. The patient and his family, members of Jehovah's Witnesses, refused blood transfusion. Urine output was virtually nil. The blood urea nitrogen (BUN) rose rapidly. Peritoneal dialysis was initiated at 6:00 P.M., June 30th, but despite careful manipulation of the intraperitoneal catheter as well as replacement of it, good outflow of dialysate could not be accomplished. Some decline of the blood urea nitrogen did occur by 8:00 A.M., July 2nd, but the patient's clinical condition did not improve and, moreover, he was seriously discomfited by abdominal distention. More effective dialysis was urgently required. With the informed consent of the patient and his family, hemodialysis was undertaken with the use of Travenol's new Ultra-Flo 145 coil primed with 500 ml. of 6 per cent dextran. The patient was attached to the kidney at 3:30 P.M., July 2nd. Several minutes later a large blood leak from the coil was discovered, and it was necessary to replace the coil, reprime, and start again (4:35 P.M.). Several minutes later, the patient's hemoglobin was 3.1 Gm./100 ml. During this time and the remainder of the hemodialysis, the patient's clinical condition remained unchanged. Blood pressure was steady at 112/60 to 120/76. Hemodialysis was terminated at 9:20 P.M., according to plan.

The next morning, the patient was much more alert and was hungry for the first time since the onset of his illness. Further diagnostic studies were undertaken without delay. Cystoscopy was done and ureteral catheters were passed to each kidney. Urine flow began promptly from both kidneys. Retrograde pyelograms revealed the presence of bilateral hydronephrosis. This and other observations led to the speculation that the cause of the patient's renal failure was bilateral ureteral obstruction due to idiopathic retroperitoneal fibrosis.

Discussion

Artificial organs generally have a relatively large vascular dead space, and this is especially true of the twin coil artificial kidney. Therefore, when used in acutely ill patients, this type kidney is usually "primed" with crossmatched blood in order to avoid abrupt dilution of the patient's blood. During the past seven years, there has been study of the effects of priming with blood diluted with crystalloid solutions ("partial hemodilution") or dispensing with any blood in the prime ("absolute hemodilution").[1-3] Cooley[2] and Gollub[3] respectively reported a total of 13 patients, all Jehovah's Witnesses, who underwent open heart surgery without receiving blood at any time. In these patients, the postoperative hematocrit was generally about 50 per cent of the preoperative value. Postoperative mob-

The Author

● Dr. Smith, Columbus, is Associate Physician, Columbus Medical Center; member of Senior Attending Staff and Director, Artificial Kidney Unit, Riverside Methodist Hospital; and Clinical Assistant Professor of Medicine, The Ohio State University College of Medicine.

From the Department of Medicine, Riverside Methodist Hospital, Columbus, Ohio. Submitted April 2, 1968.

Reprint requests to Columbus Medical Center, 1211 Dublin Road, Columbus, Ohio 43215.

TABLE 1. *Laboratory Studies*

Date		Hgb. Gm./100 ml.	Hct. %	Creatinine Mg./100 ml.	BUN Mg./100 ml.
6/29/67	8:00 P.M.	6.6	.....	.....	180
6/30/67	8.00 A.M.	....	.....	17	225
7/ 2/67	8.00 A.M.	....	....	.....	186
	3:30 P.M.	5	14	14.7	177
	4:30 P.M.	3.7	11	.....	....
	4:42 P.M.	3.1	10.5	. ....	.....
	6:43 P.M.	3.4	11.5	. .. .	.....
	9:20 P.M.	3.0	11	9.3	90
7/ 3/67	8:00 A.M.	3.7	11	10.3	97

ility was generally increased and the average hospital stay was prolonged by about one week. Nevertheless, every patient but one survived.

The patient herein reported presented with acute symptoms due to uremia and severe anemia. The use of a hemodialyzer of significant dead space (500 ml.) without a blood prime was a hazard entered upon only when there appeared to be no alternative that was less hazardous. During hemodialysis, the hemoglobin fell from 5 Gm./100 ml. to 3.1 Gm./100 ml., but this fall did not prevent dramatic clinical benefit as a result of the dialysis.

Acknowledgment: Dr. Robert Rehm was urologic consultant.

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RENAL CALCULI. — Significantly higher frequencies of renal calculi were found among the 625 parents and sibs of 106 subjects prone to calcium oxalate stone formation as compared with 576 corresponding relatives of spouses of propositi. Complete reporting was accomplished in 85.3 per cent of the relatives. Analyses ruled out monogenic inheritance but were compatible with the hypothesis that the tendency to form calcium oxalate renal stones is regulated by a polygenic system, with a lesser risk for females. One implication of this finding is that no single biochemical variable will be found that will account for the diathesis. Lifetime risk for brothers of propositi approached 50 per cent, suggesting the value of prophylaxis. Population estimates of the frequency of oxalate stones among males ranged from 2.3 to 4.2 per cent on the basis of frequencies among male relatives. The presence of single or recurrent stones among relatives was independent of whether propositi had single or recurrent stones. — Martin Resnick, B. A., Durward B. Pridgen, B. S., and Harold O. Goodman, Ph. D., Winston-Salem: *The New England Journal of Medicine*, 278:1313-1318, June 13, 1968.

Cystadenoma of the Pancreas

Report of a Case

WILLIAM KNERR, M.D., PHILIP H. TAYLOR, M.D., DAVID K. HEYDINGER, and JAMES D. BOWERS, M.D.

Introduction

ALTHOUGH the majority of pancreatic cysts are pseudocysts, true cysts (cystadenomas and cystadenocarcinomas) represent 10 per cent pancreatic cysts.[1]

Since the first successful surgical treatment of a pancreatic cyst by Bozeman in 1882,[2] surgeons have managed these cysts by a variety of operations. Unfortunately many physicians believe the best treatment of all pancreatic cysts is by internal drainage. While pancreatic pseudocysts readily respond to internal or external drainage procedures, this is *not* true for the majority of true cysts.

The following case report and discussion illustrate the importance of identifying the type of pancreatic cyst to insure proper treatment.

Case Report

A 60 year old white woman was first seen in Riverside Methodist Hospital, November 1958, with a two-year history of severe, intermittent left upper quadrant pain which occasionally radiated to the left flank. This pain was relieved by assuming the sitting position. There was no relationship to food intake nor evidence of pancreatic insufficiency. Physical examination was essentially normal except for a soft, ill-defined, non-tender mass in the left upper quadrant. X-ray examination showed a depression of the left kidney by a suprarenal mass on both intravenous pyelogram and retrograde pyelogram. Upper gastrointestinal series revealed a filling defect, apparently extrinsic, in the region of the posterior wall of the stomach. Laboratory studies were essentially within normal limits except for one serum amylase of 436 Somogyi units per 100 ml.

At laparotomy, a large pancreatic cyst in the tail of the pancreas was found and drained internally through the posterior wall of the stomach by a cystogastrostomy. Postoperatively, the patient continued to have intermittent pain and was again admitted to Riverside Methodist Hospital in July 1961 complaining of fatigue, low back pain, and a weight loss of 30 pounds with fatty food intolerance. X-rays at this time were normal and showed no masses in the area of the pancreas. The patient was seen in psychiatric consultation and started on appropriate therapy for a "psychoneurotic depressive reaction."

Between September 1964 and December 1964, the patient was seen several times for recurring left upper quadrant pain and several upper gastrointestinal series were performed, again showing a left upper quadrant mass. The mass appeared to be decreasing in size between the two examinations and surgery was not performed.

The patient was admitted again in September 1967 complaining of recurring left upper quadrant pain radiating to the back, with nausea, vomiting, and a 10-lb. weight loss. Physical examination revealed a fullness in the left upper quadrant, but no definite mass was palpable. Upper GI x-rays revealed a large mass in the area of the tail of the pancreas, indenting the posterior wall of the stomach.

At laparotomy, a large cystic mass measuring 12 cm. in diameter was found in the tail of the pan-

The Authors

- Dr. Knerr, Columbus, is Chief Resident in General Surgery, Riverside Methodist Hospital.
- Dr. Taylor, Columbus, is Clinical Instructor in Surgery, The Ohio State University College of Medicine; a member of the Courtesy Staff, University Hospital; Senior Attending Staff, Riverside Methodist Hospital.
- Dr. Heydinger, Columbus, is a member of the Senior Attending Staff, Riverside Methodist Hospital; Courtesy Staffs of University, Children's, and Mount Carmel Hospitals; Associate Professor of Clinical Surgery, The Ohio State University College of Medicine.
- Dr. Bowers, Columbus, is a member of the Attending Staffs of Riverside Methodist Hospital and St. Ann's Hospital.

From the Department of Surgery, Riverside Methodist Hospital, Columbus, Ohio. Submitted May 2, 1968.

creas. The previous cystogastrostomy was not patent and the remaining pancreas grossly appeared normal. The cyst and tail of the pancreas were resected. The cyst was described pathologically as a "multiloculated cystadenoma of the pancreas."

Discussion

Cystadenoma of the pancreas is a benign cyst, which occurs predominantly in females. These cysts may occur in any part of the pancreas but are more frequently found in the distal portion of the pancreas.[3,4]

The majority of patients with true pancreatic cysts present with upper abdominal pain and a palpable mass, which is non-tender and usually mobile. Generally there is no history of alcoholism, gall bladder disease, or previous pancreatitis.[3,4] Radiographically, the extrinsic mass often displaces the stomach forward or depresses the left kidney.[1]

Treatment of this lesion is the focal part of this case report. Excisional therapy is the treatment of choice for a cystadenoma of the pancreas. These are multiloculated lesions lined by a secretory type of epithelium. Any attempt to marsupialize such a lesion, either internally or externally, usually results in reformation of the cyst from the undrained multiloculated areas. Therefore, simple internal drainage in this lesion is an inadequate procedure, as exemplified by this reported case.

A second reason for resection of a pancreatic cystadenoma is that this lesion is a true neoplasm which undoubtedly possesses some malignant potential.[5] One final point should be stressed. Every pancreatic cyst should be examined histologically (at the time of surgery) to help identify the type of cyst present and thus permit the proper treatment.[2-4]

Summary

A case report has been reviewed of a woman who had internal drainage of a pancreatic cyst by a cystogastrostomy only to return nine years later with a recurrent cyst. A multiloculated cystadenoma of the pancreas was removed.

The importance of an accurate diagnosis to permit adequate treatment of a cystadenoma or true cyst of the pancreas is discussed.

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MISUSE OF CORNEAL ANESTHETICS. — Five cases are presented to emphasize the fact that chronic use of topical anesthetics on the eye can lead to severe keratitis and even permanent reduction of visual acuity. These reactions can be evoked in any eye that has been subjected to prolonged topical anesthesia as a means of relieving the discomfort of minor injuries. Loss of corneal epithelium (with resultant increased reliance on the anesthetic), opacification and edema of the corneal stroma and marked inflammatory changes in the anterior segment of the eye is the sequence of events that follow days or weeks of such treatment. Topical anesthetics should only be used for the purpose of obtaining transient loss of corneal sensitivity and never as part of a prolonged medical regimen. — David L. Epstein, M. D., and David Paton, M. D., Baltimore: *The New England Journal of Medicine*, 279:396-399, August 22, 1968.

Electrocardiographic-Pathologic Conference

Right Heart Disease

RALPH C. SCOTT, M.D.*

THE FORMAT of the electrocardiographic-pathologic conference (EPC) has been presented in the first article in this series.[1]

Electrocardiographic Interpretation

The electrocardiogram illustrated in Figure 1 was recorded on January 8, 1968 and displays sinus tachycardia and digitalis effect. The P waves are tall and peaked in the inferior leads (II, III, aVF) consistent with right atrial enlargement. The P waves are also predominantly positive in V_1, also consistent with right atrial enlargement. Attention is directed to the T waves in V_1 which are diphasic (−+).

A tracing recorded on January 5, 1968 (not illustrated) was similar to Figure 1 with the exception that the P waves in V_1 were even taller and the QRS complex in V_1 consisted of a small q wave preceding the R wave. The T waves in V_1 were similar to those in the illustration. A later tracing recorded on January 11, 1968 also displayed sinus tachycardia with a rate of 120. No other significant differences from Figure 1 were noted.

Summary:

(1) Right atrial enlargement
(2) Sinus tachycardia

Clinical Resume

This 71-year old Negro male was admitted to the Cincinnati General Hospital on January 5, 1968 with severe respiratory distress. He gave a history of having been "gassed" in World War I and of having had asthma ever since. He stated that for the past 10 to 15 years he had experienced exertional dyspnea, paroxysmal nocturnal dyspnea and intermittent ankle edema. During the three or four weeks prior to admission these symptoms had persisted and progressed. He also complained of aching anterior chest pain and occasional sharp chest pain with exertion.

The patient's blood pressure was 160/100; pulse rate 110 beats per minute. The venous pressure was elevated. He had clinical signs of emphysema with wheezes and rales over the chest, cardiomegaly, gallop rhythm, hepatomegaly, peripheral edema, and clubbing of the nail beds. The chest x-ray demonstrated cardiomegaly, vascular congestion, and soft miliary densities.

He was treated with oxygen, slow digitalization and diuretics. Later, he was also treated with antibiotics and bronchodilators. His arterial oxygen saturation with nasal oxygen at 3 L./min. was 91 per cent with a $PaCO_2$ of 59 mm. Later, when oxygen was discontinued, values of 41 per cent and 60 mm. Hg were obtained for oxygen saturation and $PaCO_2$ respectively. After receiving 5.25 mg. of digoxin over an eight-day period, he displayed what was thought to be possible digitalis intoxication and digitalis was discontinued. Throughout his hospitalization he remained dyspneic at rest. On his tenth hospital day, he had cardiac arrest and could not be resuscitated.

Necropsy Findings

The heart weighed 440 Gm. fresh and 421 Gm. after removal of epicardial fat. The ventricular weights were: left ventricle (LV) 118 Gm.; septum (S) 95 Gm.; right ventricle (RV) 119 Gm.; with a (LV+S)/RV ratio of 1.8, putting the heart in the pure right ventricular hypertrophy category.[2] The atrial weights were: right atrium 38 and left atrium 28 Gm. There was marked dilatation of the right ventricle with flattening of the trabeculae carneae with cupping. The right ventricular wall bowed downward and outward at the apex but formed the apex equally with the left ventricle. A healed 2 x 1.5 cm. infarct in the high posterior left ventricular wall was noted. The tricuspid valve was dilated. The posterior wall of the heart was supplied by the circumflex branch of the left coronary artery (75 per

From the Cardiac Laboratory, Cincinnati General Hospital and the Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. Submitted August 8, 1968.

*Professor of Medicine, University of Cincinnati College of Medicine and Director of Cardiac Clinics, Cincinnati General Hospital.

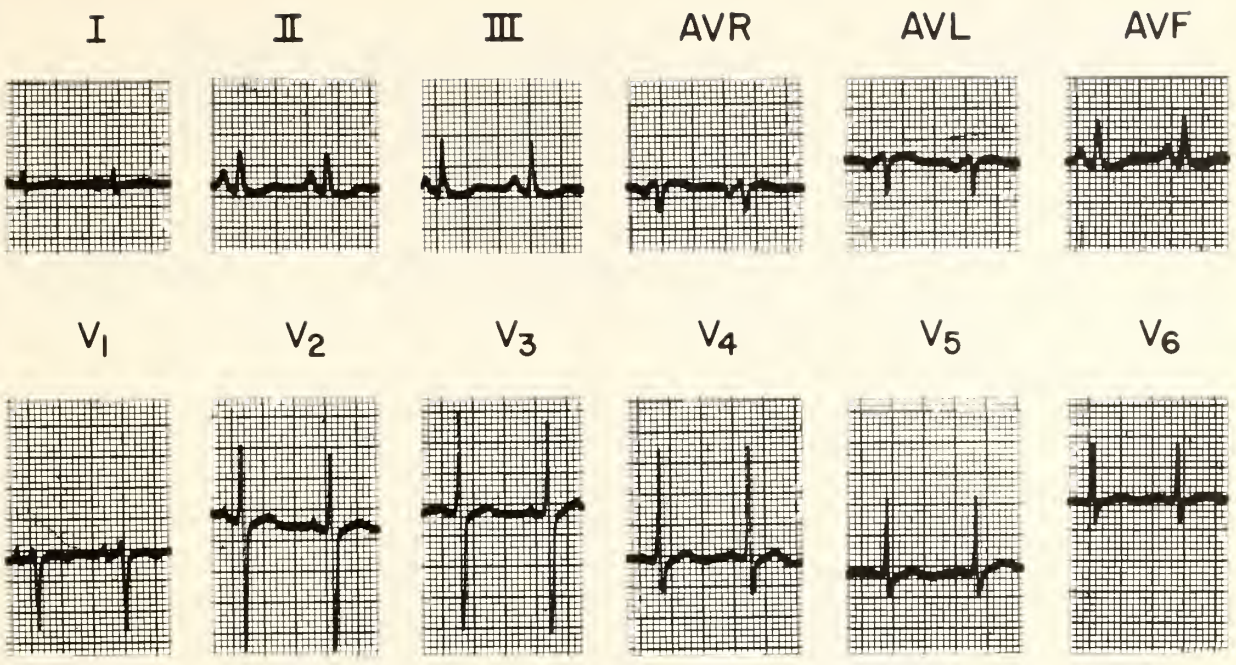


FIG. 1. *Electrocardiogram, recorded on January 8, 1968, displays sinus tachycardia, digitalis effect, and right atrial enlargement.*

cent) and by the right coronary artery (25 per cent). All the coronary artery branches were widely patent.

At autopsy the lungs displayed evidence of severe pulmonary emphysema, lobular pneumonia, and tracheobronchitis.

Anatomic Diagnoses:

(1) Right ventricular hypertrophy, pure
(2) Right ventricular dilatation, severe
(3) Right atrial enlargement
(4) Infarct, healed, left ventricular posterior wall
(5) Pulmonary emphysema, severe

Comments

This case is an example of marked isolated right ventricular hypertrophy with right ventricular dilatation and right atrial enlargement, secondary to chronic lung disease. The electrocardiogram is certainly not diagnostic of right ventricular hypertrophy, although it does display a pattern consistent with right atrial enlargement.

More attention perhaps should have been directed toward the T wave configuration in V_1. As noted, the T waves in V_1 are diphasic (−+). The T waves are not infrequently inverted in V_1 in normal adults. They also may be normally diphasic in V_1 but, as has been recently pointed out, they are always +−, corresponding with the normal counterclockwise inscription of the T loop in the horizontal plane.[3] If the T loop is inscribed in a clockwise direction in the horizontal plane in right ventricular overload and if the long axis of the T loop lies along the isoelectric line of lead V_1 (plus 25°) then the T wave in V_1 will be inscribed as a −+, which is abnormal. In this case, had more attention been given to this direction of inscription, it might have been possible to have suggested that there was right ventricular dilatation.

The small high posterior infarct noted anatomically was not recognized in the electrocardiogram. In retrospect, possibly more attention should have been directed to the relatively tall R waves in V_2 and V_3, although these may, in fact, have also been related to the anatomic right ventricular hypertrophy.

Acknowledgments: The author wishes to express his thanks to Dr. Sandra Conradi who performed the detailed necropsy examination in this case, and to Dr. Robert J. Norris, Dr. Emmett Conyers, and Dr. Donald Romhilt for their participation in the electrocardiographic and clinical correlation.

Supported in part by Public Health Service Research Grant HE-08578. Additional support was received from the Heart Association of Southwestern Ohio, Inc.

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3. McCaughan, B.; Primeau, R. E., and Littmann, B.: The Precordial T Waves. *Amer. J. of Cardiol.*, 20:660, 1967.



NEWS AND Organization Section

AMA Miami Beach Session . . .

Annual Clinical Convention Scheduled December 1-4: Excellent Scientific Program in Store for Physicians

SCIENTIFIC SESSIONS of wide medical interest are planned for morning and afternoon Monday through Wednesday, December 2-4, at the American Medical Association's 22nd Clinical Convention in Miami Beach, Florida.

Morning topics December 2 include the anemias, thrombophlebitis, and obstetrics. The afternoon program includes discussion of white cell disorders and diseases of the lymph nodes, management of claudication, cerebral ischemia due to neck vessel occlusion, and gynecology.

Tuesday, December 3, topics are cardiology, gastrointestinal diseases, proctology, and — in the afternoon —new approaches in cardiology, bacterial skin infections, and the skin and sunlight.

Discussions on sex will be held Wednesday morning, December 4, to include such topics as marital problems, changing sex values, preadolescent and adolescent sex education, and sex and the senior citizen. Hypertension and the kidney also will be studied at the morning session.

Wednesday afternoon's topics include pulmonary diseases, respiratory ills in children, and more on the kidney.

Scientific sessions will be held in Miami Convention Hall. Total registration is expected to be about 10,000, including 4,500 physicians; 300 medical students, nurses, and members of allied medical professions; 800 industrial exhibitors; and 4,400 guests of physicians and exhibitors.

The October 21 issue of *The Journal of the American Medical Association* will carry the Scientific Program for the Clinical Convention.

Exhibits

A showcase of scientific achievements and studies will be seen. A total of 125 scientific exhibits, covering a variety of medical disciplines, will be set up at the convention center. The displays will be available for viewing from noon Sunday, December 1, until the session ends Wednesday afternoon.

Live color telecasts dealing with medical problems will be shown on Monday, Tuesday, and Wednesday to compliment the general session by providing additional educational information. The television programs will cover obstetrics-gynecology, cerebral vascular disease, and amputee and stroke rehabilitation.

Also, about 30 medical motion pictures will be shown as part of the scientific program.

At least five premiere showings are planned. Among these are "Shock and Recognition and Management" and "Granulomatous and Ulcerative Colitis: Diagnosis and Differential Diagnosis."

A film symposium, with panel discussion, is planned on "Problems of Chest Pain." A question-and-answer session will be included.



AMA

22ND CLINICAL CONVENTION

MIAMI BEACH

DECEMBER 1-4,1968 · CONVENTION HALL

. . . the American "Riviera." Where glittering luxury hotels tower above glamorous Collins Avenue; and medicine, sea and sunshine mix in a delightful subtropical setting.

Register now, and be on hand for the world's largest winter medical meeting—the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

ACS Sectional Meeting Scheduled in Louisville, February 24 - 26

The American College of Surgeons has scheduled three Sectional Meetings in 1969: February 3-5, Omaha, Neb.; February 24-26, Louisville, Ky., and March 10 - 12, Boston, Mass., the annual combined meeting for doctors and nurses.

Dr. James C. Drye, Professor of Surgery, University of Louisville School of Medicine, is chairman of the local advisory program committee for the Sectional Meeting in Louisville at the Brown Hotel. This meeting will feature the specialties of gynecology-obstetrics and neurosurgery in addition to daily sessions in general surgery.

A symposium on trauma will open the meeting, featuring developments in transportation and management of the injured, and various acute injuries. The "Louisville Plan" — a pioneer plan of direct transport of the seriously injured and ailing from ambulance to operating room or intensive care unit will be reviewed. An innovation at this meeting will be "Fireside Chats" — informal, end-of-the-day discussions with program participants, open to all questions from all registrants.

Official housing forms for all meetings are available from: Mr. T. E. McGinnis, Manager of Exhibits and Meeting Arrangements, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

Ohio Academy of General Practice Elects Officers for Year

Dr. George D. Clouse, Columbus, was installed as President of the Ohio Academy of General Practice at that organization's annual assembly in Dayton, July 30 - August 1. He succeeded Dr. B. Leslie Huffman, Jr., of Toledo.

The statewide 1800 member family physician organization held its meeting at the Dayton-Sheraton Hotel. In honor of the organization's purposes, Governor James A. Rhodes and Dayton Mayor Dave Hall proclaimed the meeting period as Family Physician Week.

Other new officers installed are Drs. Fred V. Light, Cleveland, President-Elect; Robert S. Young, Johnstown, Vice-President; Walter G. Engel, Cincinnati, Vice-President; David A. Barr, Lima, Treasurer; Sanford Press, Steubenville, Speaker; Earl F. Ward, Toledo, Vice-Speaker; William P. Smith, Jr., Columbus, AAGP Delegate; and B. Leslie Huffman, Jr., Toledo, AAGP Alternate. Elected directors are Drs. James A. Rodeghero, Dayton; Harry Snyder, Jr., Toledo; H. Judson Reamy, Dover; James C. Good, Columbus; and Paul Ruksha, Mingo Junction.

Report Progress During First Year Of Cincinnati CONMED Program

Cincinnati's CONMED program — a comprehensive cooperative effort by several community institutions to meet the continuing educational needs of individual physicians in the area — has completed its first year.

The record shows 20 courses presented (with enrollment going as high as 250), and 773½ hours of instruction offered to 1631 participants.

James F. Schieve, M. D., director of CONMED, reported that the year's experience confirmed the "need for a community program in continuing education for physicians" and further said that continued growth seems assured.

Sparked by Cincinnati Academy of Medicine interest, CONMED emerged after several years' planning, as a cooperative effort by the Academy, four community hospitals — Bethesda, Christ, Good Samaritan, and Jewish Hospitals — and the College of Medicine of the University of Cincinnati.

Other CONMED developments include arrangements for teaching programs with several Dayton hospitals and a series of seminars at Washington Court House in cooperation with the Ohio Academy of General Practice.

Paralleling CONMED has been the development of another communication vehicle for physicians. "What Goes on K. I. O." — a monthly listing of postgraduate courses scheduled in the entire Kentucky, Indiana, and Ohio area, is published by the Medical Foundation of Cincinnati, an affiliate of the Academy of Medicine of Cincinnati. It is edited by Dr. G. S. Accetta, director of postgraduate education for the Foundation.

Two Ohio Grants Promote Improved Nursing Education Programs

Two Ohio programs are among 21 new Projects for Improvement in Nurse Training, sponsored under the federal Nurse Training Act by the Division of Nursing of the National Institutes of Health.

One project is that at Ohio State University, Columbus, for revision and evaluation of baccalaureate nursing curriculum — a five-year program.

Another is at Providence Hospital, Sandusky, for faculty development and improved curriculum in medical-surgical nursing — a four-year program.

According to the Division of Nursing, 16 nursing education programs in hospitals and community colleges are participating in nine of the new Projects for Improvement in Nurse Training, and projects are also underway in 12 graduate and undergraduate nursing programs in colleges and universities. Funds now awarded to launch and carry the 21 new projects through their first year of operation total $1,078,902.

News Media Reflect 'Team Spirit' in Cleveland's Pioneering Organ Transplant Surgery

CLEVELAND DOCTORS, well known for their pioneering work in organ transplants, have taken a giant step in the advance of medicine and surgery. On September 5, a Cleveland team, an Akron patient, and a donor became principals in the first heart transplant performed in the Midwest.

News media quickly responded to the impact of the situation. The *Cleveland Plain Dealer* published a full-page feature article by Medical Writer Fraser Kent, and headed the story with a photograph of "the team"—some 20 persons. The *Cleveland Press* announced the event with a four-column banner head over an article by Medical Writer Joe Collier. The *Akron Beacon Journal* featured the patient angle (the patient being from Akron) with a banner story by William Vance. Other newspapers similarly played up the pioneering transplant. Radio and television newscasters were equally vigilant in heralding medicine's latest advance.

Pioneering heart surgery goes back several decades in the Cleveland area, and a recent article in *The Journal* documents early developments. "The Last Great Northwest of Surgery," published in the March, 1968 issue traces surgical developments as seen by Dr. Claude S. Beck.

Extensive Background

Fraser Kent noted: "The Cleveland Clinic's reputation as a heart specialist center was already established in the late 1940's, enhanced by top-rated men such as Dr. Irvine H. Page, Dr. Willem J. Kolff, and Dr. F. Mason Sones, Jr."

In 1956, a four-man team made medical history with the first "stopped heart" operation. The team consisted of Dr. Donald B. Effler, Dr. Laurence K. Groves, Dr. Sones, and Dr. Kolff. The Clinic team also played an early role with internal mammary artery implantation for patients with coronary disease, achieving a remarkably high survival rate.

Significant among reports was a note that the heart transplant was one of nine heart operations performed on that same day in the Cleveland Clinic cardiovascular unit. One newspaper account noted: "Transplants of kidneys are more or less routine."

Akron Patient

Patient for the transplant was D. Howard Lawson, 50-year-old Akron resident, referred to the Clinic by his physician, Dr. J. Harlan Dix. It was the patient's third trip to the Clinic. On two previous visits a suitable donor organ was not available.

The donor was Mrs. Barbara Lancaster Smith, of Blytheville, Arkansas, who was taken to St. Vincent Charity Hospital in critical condition following a traffic accident. She was later transferred to the Cleveland Clinic after permission for organ donations was received from members of the family. At least one newspaper article made a feature of assurance that the donor was legally dead by all available standards.

Significant also is the fact that organs from the same donor played roles in three separate operations — two kidney transplants as well as the heart operation.

Although names were used in news accounts, news media personnel did respect a professional request that individuals not be singled out for their personal achievements. The three-man surgical team consisted of Dr. Effler, Dr. Groves, and Dr. Rene G. Favaloro. Names of the kidney transplant teams were not given, although again leading surgeons in the field were mentioned by name.

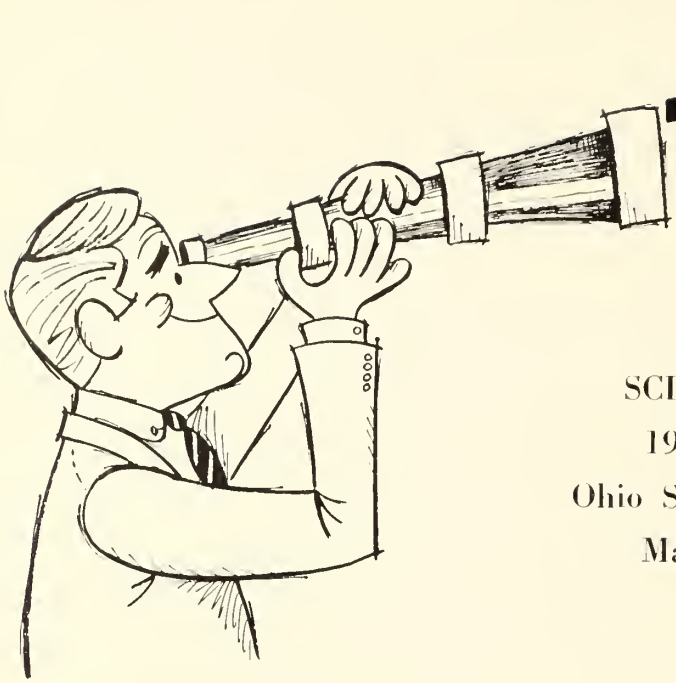
Another significant observation made by reporters was the announcement by doctors that the purpose of organ transplants is not primarily to prolong life. Of team members and patient, one reporter said, "They hope to restore him to productive activity."

Good public relations is further reflected in editorial comments of the Plain Dealer, which noted in part:

"Despite the fact that transplant no longer is unique, it remains one of the most dramatic and hopeful forward steps in modern day surgery.

"Perhaps more than any other operation, the transplant requires an experienced team of doctors . . . The specialists who make up the Clinic team are one of four such groups around the nation . . . This geographical arrangement of the centers means that patients around the country can be dispatched to a hospital in their area of the nation to facilitate transplant service until the operation becomes more generally available. . . .

"This city can be proud that Cleveland has staked out an early position of leadership in this medical-surgical advance."



FIRST CALL FOR ENTRIES

SCIENTIFIC EXHIBITS
1969 Annual Meeting
Ohio State Medical Association
May 12-16. Columbus

SET YOUR SITE on the 1969 Annual Meeting of the Ohio State Medical Association. Yes . . . we did say 1969 ! ! NOW IS THE TIME TO PLAN YOUR EXHIBIT by applying for exhibit space. (Application on opposite page). Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be MAY 13, 14, and 15. Be certain to share your scientific experiences with your fellow colleagues.

This Year's theme "The Scope of Medicine — Prevention" will be carried out through the entire Annual Meeting.

Don't delay in sending us your application for exhibit space. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Deadline for entries: Deadline for applications for the exhibit is January 30, 1969. Applications should be made to: Committee on Scientific Work, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

Placement and Dismantling: All exhibits must be in place by 12:00 NOON, Tuesday, May 13, 1969. The hall will be available on Monday, May 12, and Tuesday morning, May 13, for the placement of exhibits. Removal of exhibits may be started at 4:30 P.M., Thursday, May 15.

Facilities: Each Scientific Exhibitor will be provided with a booth or wall space, a standard sign, necessary electrical outlets, shelves, and transparency cases. The booth will be of uniform color and design. Back and sidewalls will be pegboard, making them extremely functional for accommodating all kinds of charts and specimens. Blue fluorescent fixtures are a part of the background and will be spaced on each exhibit to give adequate lighting. Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitors as well as the costs of cards, signs, etc., where a part of the exhibit.

The booth sketch on the facing page of the application shows the type of booth which will be provided.

Don't be disappointed . . . forward your application by return mail. After your application has been approved, a complete set of Rules and Regulations Governing Scientific Exhibits will be mailed to you.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1969 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, Ohio, May 12-16

. Title of Exhibit: _____

. Name(s) of Exhibitor(s): _____

_____

Institution (if desired): _____

City _____

. Do you have a built-in exhibit? _____

. Description of Exhibit: (Attach 200 word description to this blank)

. Exhibit will consist of the following: (Check which)

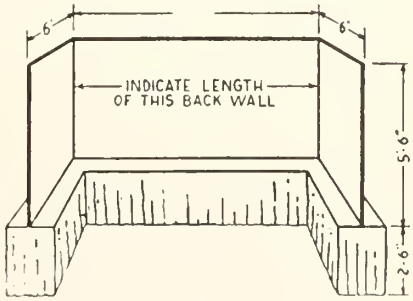
Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____
(Describe)

. Booth Requirements: (See Sketch)

Back wall _____ All sidewalls are 6′ deep
(Indicate Footage)

Shelving: Shelves are 12 inches deep at a height of 2 feet 6 inches from the floor. Please indicate if you require shelves (yes or no) _____.



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

. Transparency Cases:

Needed? (yes or no) _____
If answer "yes," give following information:
Number of transparencies to be shown and size of each

_____

_____

_____

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

ate _____ _____
Signature of Applicant

_____
Mailing Address, Street

_____
City, State, Zip Code

END APPLICATION TO: COMMITTEE ON SCIENTIFIC WORK, OHIO STATE MEDICAL ASSOCIATION, 17 SOUTH HIGH STREET, SUITE 500, COLUMBUS, OHIO 43215

Deadline For Filing Applications, January 30, 1969

Outstanding Scientific Exhibits At OSMA Annual Meeting

SCIENTIFIC EXHIBITS provided important features of the 1968 OSMA Annual Meeting in Cincinnati, May 13-17. Out of some 40 Scientific Exhibits, a judging team selected several as outstanding. This procedure was in keeping with recommendations of the Committee on Scientific Work approved by The Council. The authorized award in each case consists of a certificate of recognition, a permanent type plaque, and, in the case of gold, silver, and bronze awards in the two fields of original investigation and teaching, monetary gifts. A summary of exhibits selected to receive recognition was printed in the July issue of *The Journal,* and a follow-up article on some of them was published in the September number. Following are additional summaries of individual outstanding exhibits. Others will be published in subsequent issues.

* * *

Silver Award in Teaching Goes to Exhibit on Eye Diseases

The exhibit entitled "Anterior Segment Eye Diseases," presented by Dr. Ira A. Abrahamson, Sr., and Dr. Ira A. Abrahamson, Jr., Department of Ophthalmology, University of Cincinnati College of Medicine, was the Silver Award winner in the Teaching Field.

This exhibit, developed through years of experience, has received wide recognition in the medical profession.

More than 1000 Kodachrome slides of common and rare diseases of the anterior segment of the eye were selected by the sponsors from a collection of over 30,000. The observer was able to study each photograph and make a tentative diagnosis. By simply flipping the tab under each photograph, the observer was then able to compare his evaluation with the correct diagnosis.

Panels were changed daily so that a large number of slides could be shown and a projection device was mounted to show a sequence of events in the stages of a disease in the progressive steps of operation.

In addition to its recognition by the Ohio State Medical Association, the exhibit received the following awards:

American Academy of Ophthalmology, Chicago, October, 1966 — Second Award in Teaching.

American Academy of Pediatrics, Washington, D. C., October, 1967 — First Gold Award in Teaching.

Pan-American Association of Ophthalmology, Argentina, March, 1968 — First Award in Teaching.

Because of the many expressions of interest in obtaining slides from the collection, Dr. Abrahamson has written and compiled a book entitled *Color Atlas of Anterior Segment Eye Diseases,* published by McGraw-Hill Company, New York.

* * *

Laser in Cancer Research Exhibit Receives Honorable Mention

Honorable Mention in the Field of Original Investigation was awarded the exhibit entitled "The Laser in Cancer Research" sponsored by a team associated with the Laser Laboratory, Cincinnati. The team consists of Leon Goldman, M. D., R. J. Rockwell, Jr., M. Sc., Edmond Ritter, M. Sc., V. E. Siler, M. D., Donald Blaney, Ph. D., M. D., James Fidler, M. D., Robert Meyer, Robert Otten, and K. W. Kitzmiller, M. D.

Specifically, the facility is the Laser Laboratory, Children's Hospital Research Foundation, Medical Center of the University of Cincinnati. The laboratory is supported by the John A. Hartford Foundation, Laser Safety Program, Public Health Service Research Grant UI-00413 from the National Center for Urban and Industrial Health.

The exhibit summarized seven years of laser cancer research at the laboratories. A laser attached to a microscope has been used to study the effect of the laser in tissue cultures of melanoma cells and HeLa cells. Experiments in animal cancer research have been done with the treatment of various tumors including melanoma, adenocarcinoma of the breast, thorotrast induced angiosarcomas of Swarm, polyoma virus tumors of Sabin, and methylcholanthrene induced tumors.

In clinical investigative studies, the laser has been used on accessible melanomas, primary, and metastatic, multiple basal cell and squamous cell epitheliomas

Outstanding Annual Meeting Exhibits



At the 1968 OSMA Annual Meeting, the Silver Award in the Teaching Field went to this exhibit entitled "Anterior Segment Eye Diseases," sponsored by Dr. Ira A. Abrahamson, Sr., and Dr. Ira A. Abrahamson, Jr., of Cincinnati.



Originating in the Laser Laboratory of the University of Cincinnati Medical Center, this exhibit entitled "The Laser in Cancer Research," received Honorable Mention in the Field of Original Investigation at the 1968 OSMA Annual Meeting.

and malignant tumors of the blood vessels, and metastatic adenocarcinomas. Accessibility of the lesion, the size of the lesion, the energy and power densities of laser instrumentation are factors affecting results.

Control surgical techniques have included the scalpel, high frequency electrosurgery, cryosurgery and the plasma arc scalpel. Laser cancer surgery is an investigative form of treatment and sponsors caution that it should not replace conventional methods. Special treatment centers with multidisciplined research teams and planned safety programs are necessary for such investigative studies.

In selected cases with accessible malignancies, Dr. Goldman said, a Laser Advisory Board such as the one at the Medical Center of the University of Cincinnati, should review the possibilities and limitations of laser surgery, either alone or with adjuvant therapy.

* * *

Blood Cytology in Cancer Exhibit Given Honorable Mention

The exhibit entitled "Blood Cytology in Cancer," sponsored by a team from the Department of Pathology, Ohio State University College of Medicine, was awarded Honorable Mention in the Field of Original Investigation. The team consisted of Thomas D. Stevenson, M. D., Joan C. Mattson, M. D., and Emmerich von Haam, M. D.

The principal purpose of the exhibit was to summarize for the practicing physician progress in this area of cytologic research.

The exhibit consisted of text and photographs displayed on transparency boxes describing the current status of the examination of peripheral blood for circulating tumor cells.

Representative examples of tumor cells recovered from the blood of patients along with the histologic characteristics of the primary tumor and other types of cytologic examinations were displayed.

The techniques utilized in examining blood for circulating tumor cells were described as well as a notation of possible sources of error in these techniques.

The use of fluorescent methods were briefly described as well as changes occurring in normal cells in individuals with cancer — the so-called "malignancy associated changes."

* * *

Post Phlebitic Disease Exhibit Given Honorable Mention

Honorable Mention in the Teaching Field was awarded the exhibit entitled "Post Phlebitic Disease," sponsored by E. A. Husni, M. D., Huron Road Hospital, East Cleveland.

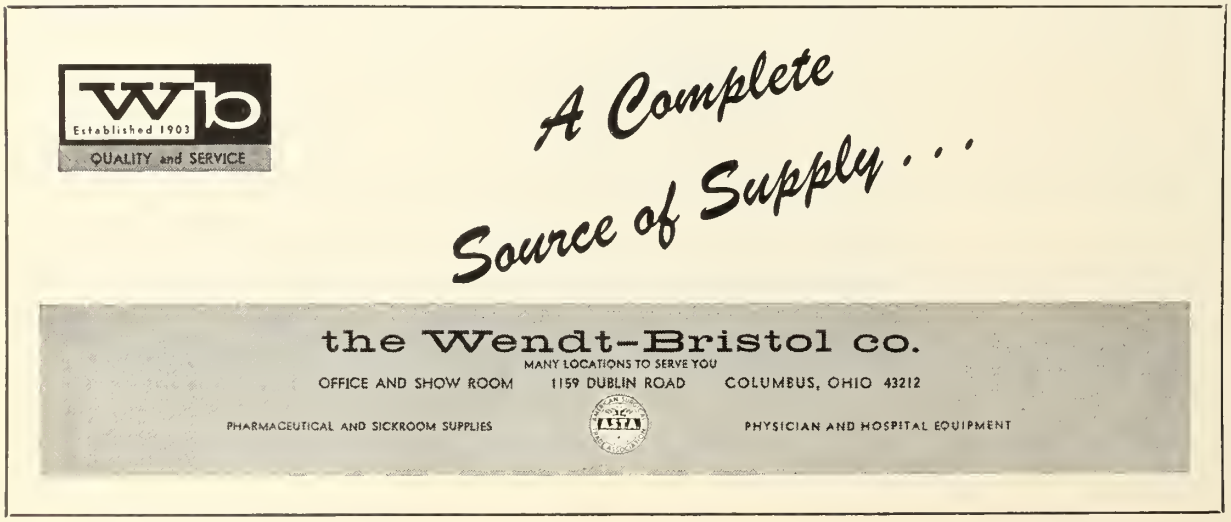
This exhibit was based upon the evaluation of more than 240 case records documented over an eight year period with phlebograms, pressure studies, and color transparencies.

The exhibit material was presented in four panels. Panel 1 depicted the underlying pathology of post phlebitic disease of the leg including illustrated transparancies of phlebograms. Panel 2 illustrated hemodynamics studies pertaining to venous pressures and ambulatory venous hypertension.

Panels 3 and 4 illustrated the various patterns and locations of venous involvement with phlebograms, transparancies and venous pressure studies, outlining the treatment applicable to each.

Following are exampes of pattern presentation:

1. Flap procedure with ligation of perforators.
2. Cross-over vein bypass graft utilizing the normal saphenous vein from the opposite side for lesions above the level of the superficial femoral vein.
3. Autogenous vein bypass graft for lesions below the groin (an original procedure).
4. The suitable type of skin graft for these post phlebitic skin lesions of the leg.
5. Supportive measures.
6. Number of patients treated in each type.





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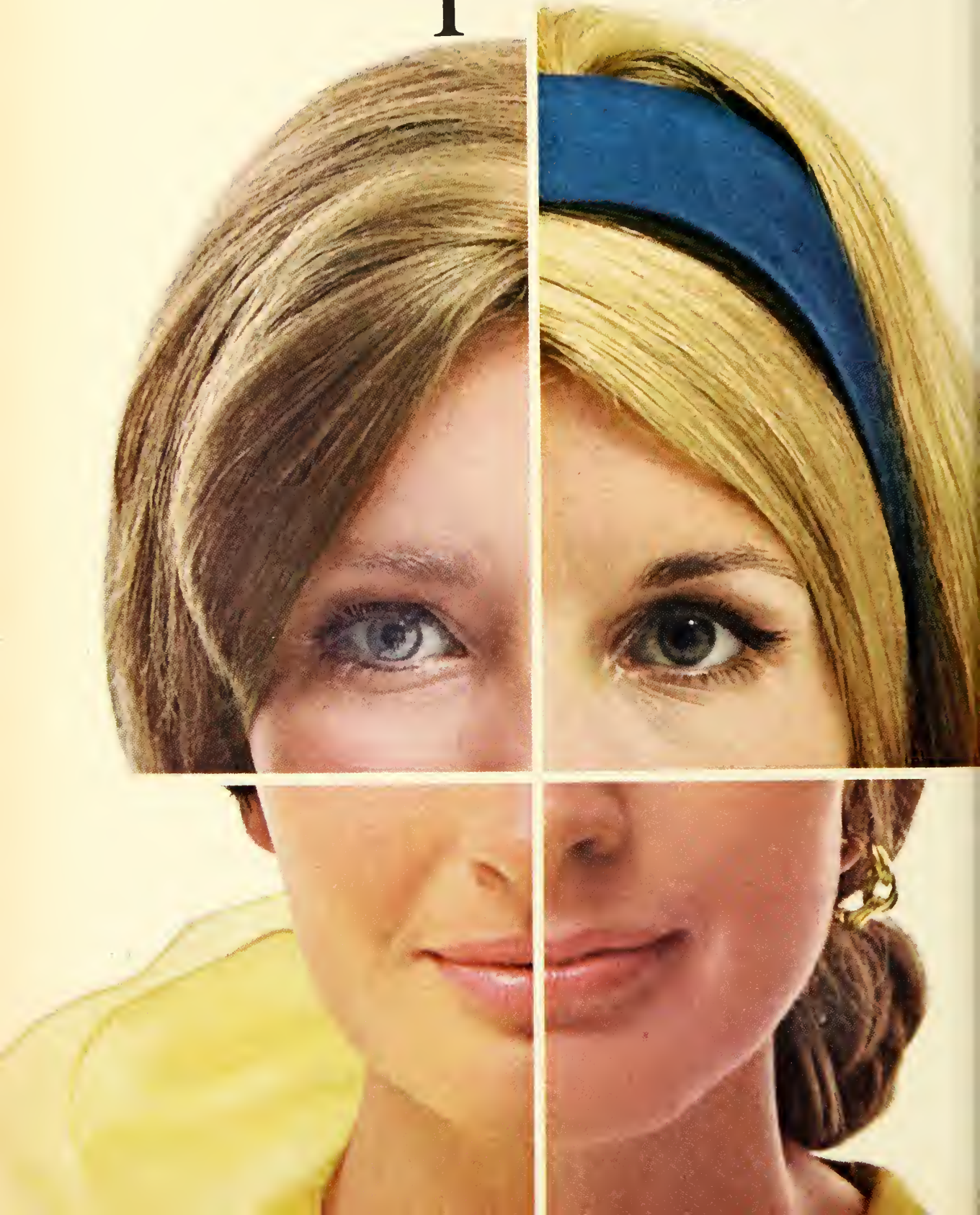
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Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
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Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

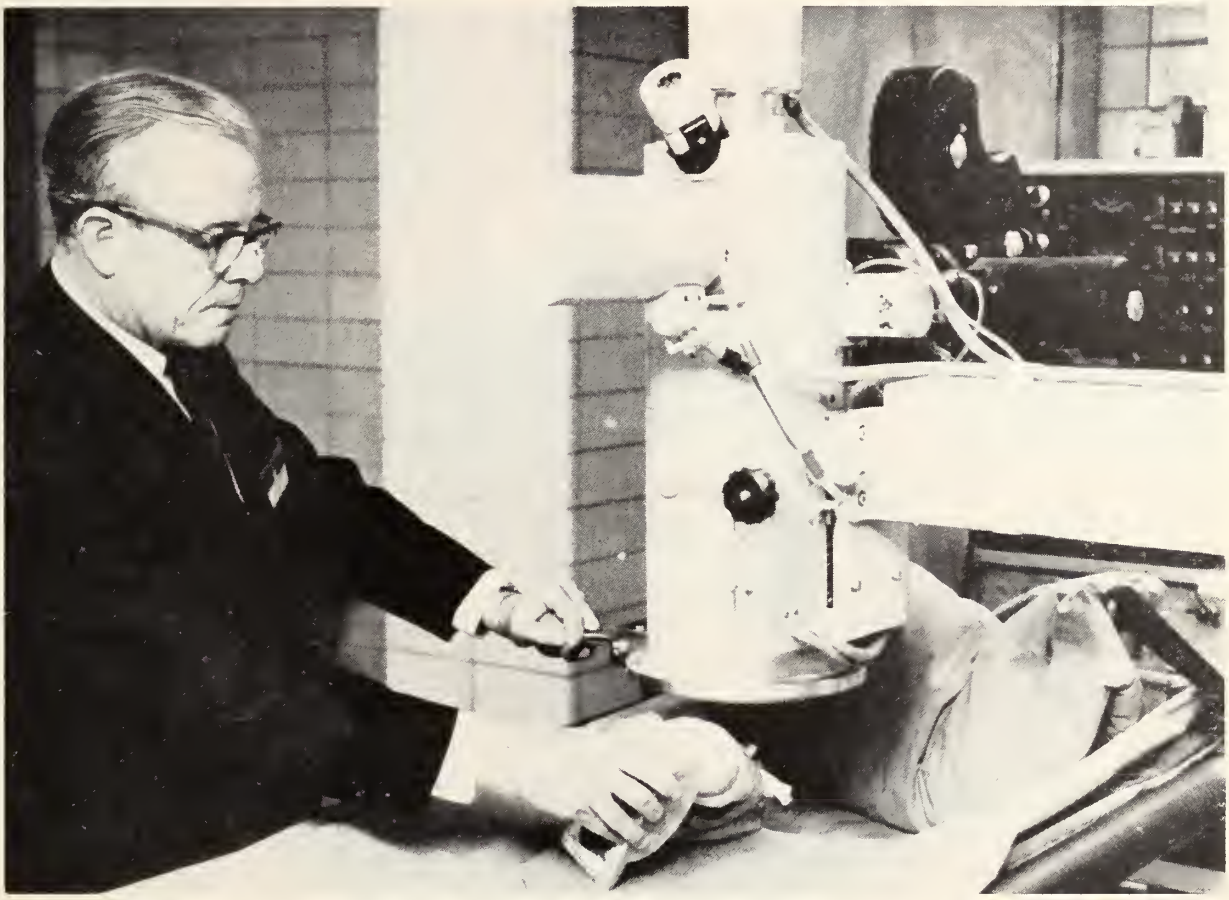
Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
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in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet



Cleveland Team Pioneers in Stereo Angiography



Dr. F. Mason Sones, Jr., demonstrates use of the stereo angiography equipment in the Cardiac Laboratory of Cleveland Clinic. He holds a heart model below the image intensifier approximately the distance involved when a patient occupies the cradle.

Movies of Patients' Heart Areas Viewed in Three Dimensions

Stereo motion pictures provided interesting experiments at movie houses, but went little beyond that stage. Stereo television is still in the talking stages. But both stereo motion pictures and TV have added a new dimension to coronary arteriography as developed by Dr. F. Mason Sones, Jr., and his colleagues at the Cleveland Clinic Foundation.

In cooperation with optical and electronics engineers at North American Philips Company, the Cleveland team has developed to a practical level stereo x-ray moving pictures of the coronary arteries and related areas of the heart. Leading up to practical application of the procedure were some five years of research and development.

The Cleveland Clinic Foundation now has converted to stereo equipment in two of its four Cardiac Laboratory examining rooms. Dr. Sones, head of the Department of Cardiovascular Disease and the Cardiac Laboratory, and his colleagues perform from 12 to 20 coronary arteriographies daily. Where indicated, stereo techniques are taking over.

Dr. Sones feels that stereo angiography offers several advantages over two-dimensional arteriography — more accurate manipulation and positioning of the catheter, more accurate positioning of the patient for clinical procedures, increased level of diagnostic information due to depth perception of the vascular system, and perhaps the first true look at the relative position of elements in the area under examination.

Versatility of the technique was demonstrated by Dr. Sones and other members of the team before the American College of Chest Physicians which met at the Cleveland Clinic Educational Foundation earlier this year. The demonstration originated from the Cardiac Laboratory and the image was transmitted to a viewing screen in an auditorium where the chest physicians were gathered. Members of the audience wore polarized glasses to see the demonstration in depth.

Group viewing is by means of a television screen and polarized glasses, but the diagnostician uses a somewhat simplified procedure, viewing the pictures with a lorgnette-type device.

no gag



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DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

...ase you're curious, back in the 1700's paregoric was ...g used for diarrhea, but since the state of the pharma...ical art was extremely primitive, fungus growth in ...medication was a problem. Bitter-tasting camphor ... added to prevent such growth and anise oil was ...d in an attempt to cover up the camphor taste. ...-quel Liquid is a modern formulation that does not ...in either of these outdated ingredients.

...ion: With use of DIA-quel Liquid observe the usual ...autions associated with opium derivatives and anti...nergies.

...ge: Usual adult dosage: 1 or 2 tablespoonfuls (15 ... ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's ...: ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

... Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

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Medicine Plays Leading Role in Liaison with Other Groups

Medicine figured strongly in meetings with other associations during August and September.

Dr. Edward R. Annis, Miami, Florida, member of the Board of Trustees of the American Medical Association, addressed an overflow crowd at the opening session of the American Society of Association Executives, August 26 in Atlanta, Georgia. His subject was "Executive Health."

At the same convention, Hart F. Page, Executive Secretary, Ohio State Medical Association, spoke on the topic "Determination of Association Policies."

The ASAE is a 2800-member organization of executives of professional and trade associations throughout the United States.

The Ohio affiliate of the ASAE, the Ohio Trade Association Executives, met September 5 and 6 in Dayton.

Leadoff speaker was Dr. Jack Schreiber, Canfield, member of the OSMA Committee on Scientific Work and other committees of the Association. His topic was "The Last Candle."

Robert A. Lang, executive secretary of the Academy of Medicine of Cleveland and Cuyahoga County Medical Society, spoke on "What Do You Mean 'What Do You Mean?' "

Closing luncheon speaker at the Ohio meeting was Dr. Richard Bates, Detroit, who told the executives "How to Live to Be 100."

On the program committee for the Ohio meeting were E. A. Graber, secretary of the Ohio Health Commissioners Conference, Chairman, and Charles W. Edgar, Director of Public Relations for OSMA.

Research in Patient Care Stressed In Assistant Dean Appointment

Dr. Gerald T. Kent, associate clinical professor of medicine at Case Western Reserve University School of Medicine, has been appointed assistant dean of the School of Medicine. The announcement stated that his responsibilities will be in the planning of a program to develop better teaching and research in patient care.

A background study on the feasibility of such a project is now being done under a grant from the Elizabeth Severance Prentiss Foundation.

A graduate of Ohio Wesleyan University and Western Reserve University School of Medicine, Dr. Kent is a diplomate of the American Board of Internal Medicine. Among appointments, he is an associate physician on the staff of University and Benjamin Rose Hospitals. Also he is co-director of the Diabetes Association of Greater Cleveland and trustee of the Health Fund.

TAO®(triacetyloleandomycin)

Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.



J.B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

Ad Astra

Veo L. Beck, M. D., Cleveland; Meharry Medical College, 1918; aged 75; died August 19; former member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in Cleveland, Dr. Beck was active in community, and fraternal organizations of his community. Among affiliations he was a member of the Presbyterian Church. Two nieces and a nephew survive.

Eldon Raymon Dykes, M. D., Honolulu, Hawaii; University of Tennessee College of Medicine, 1952; aged 31; died July 31; former member of the Ohio State Medical Association; member of the American Medical Association and the American Society of Plastic and Reconstructive Surgery; Fellow of the American College of Surgeons. A former Clevelander, Dr. Dykes was associated with the Cleveland Clinic. He moved to Honolulu in 1963 to join the Straub Clinic there. His widow and four children survive.

William Morris Fischbach, M. D., Cincinnati; University of Cincinnati College of Medicine, 1938; aged 56; died August 17; member of the Ohio State Medical Association, the American Medical Association, and the American Geriatrics Society. A practitioner for about 30 years in the Cincinnati area, Dr. Fischbach was a third-generation member of a family of physicians and formerly associated with the Fischbach Memorial Clinic. During World War II he served with the Navy Medical Corps and was a member of the American Legion. Other affiliations include membership in several Masonic bodies. Surviving are his widow, three daughters, two sons, and his mother.

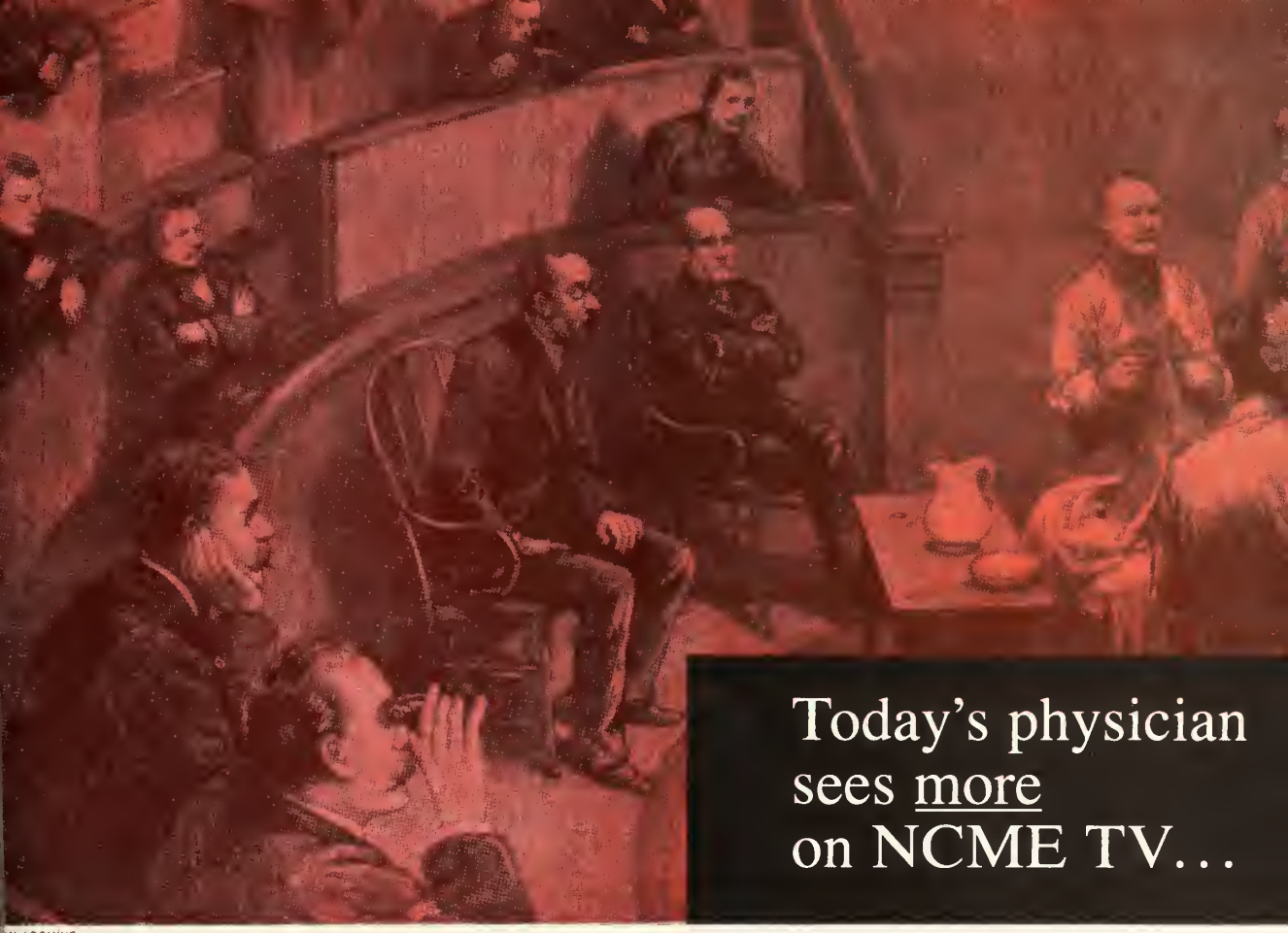
Thomas Cain Hadley, M. D., Holgate; Tufts University School of Medicine, 1956; aged 37; died July 29. Dr. Hadley's practice in the Holgate area extended over about five years. For about three years he was in residency training at Maumee Valley Hospital, Toledo. Dr. Larry L. Hadley, of Norwalk, is one of three brothers who survive. Other survivors are his widow, a daughter, and his parents.

Harry A. Haller, M. D., Lakewood and Cleveland; Western Reserve University School of Medicine, 1934; aged 60; died August 27; member of the Ohio State Medical Association, the American Medical Association, and the International Anesthesia Research Society; Fellow of the American College of Surgeons. A surgeon of more than 30 years' standing in the Cleveland area, Dr. Haller was chief of staff at Deaconess Hospital and associated with other Cleveland area hospitals. Active in medical organization work, he served on numerous committees of the Academy of Medicine. In 1959 he was named Academy president-elect, but resigned before assuming the presidency for health reasons. He was a past president of the board of consultants for the Greater Cleveland Safety Council, and a past president of the local Kiwanis Club. During World War II he served with the Navy Medical Corps. Among survivors are his widow, two daughters, two stepsons, and four sisters.

Jacob R. Heller, M. D., Cleveland; Ohio State University College of Medicine, 1928; aged 64; died August 2; member of the Ohio State Medical Association, the American Medical Association, the American Academy of General Practice, Industrial Medical Association, and the American Physicians Fellowship. A practitioner of long standing in Cleveland, Dr. Heller was associated with a private industrial clinic for about 25 years. Among affiliations he was a member of the Masonic Lodge, B'nai B'rith, and the Knights of Pythias. Surviving are his widow, two daughters, a son, four sisters, and a brother.

Harry Matthew Lowell, M. D., Hamilton; Northwestern University Medical School, 1914; aged 76; died August 14; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Lowell's professional career extended over 54 years and 48 of those years were served in the Hamilton area. Dr. Lowell served on the staff of the Mayo Clinic for two years and was on active duty with the Army Medical Corps during World War I before he moved to Hamilton. He was a member and past president of the Lions Club, a member of the 40 and 8, the Elks Lodge, the Catholic Church, Knights of Columbus, and the Fraternal Order of Police. Survivors include a son and three daughters.

Kenneth Francis Lowry, M. D., San Clemente, Calif.; Ohio State University College of Medicine, 1928; aged 68; died August 9; member of the Ohio State Medical Association, the American Medical As-



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☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

sociation, Central Surgical Association, and the American Association for the Surgery of Trauma; diplomate of the American Board of Surgery. A native of west central Ohio, Dr. Lowry returned to the Troy area to practice in 1933 after advanced medical training in the New York area. During World War II he served in the Army Medical Corps. He moved to California in 1960. Affiliations included memberships in the Elks and Masonic Lodges, the American Legion, VFW, and the Kiwanis Club. Among survivors are his widow, two sons, and a brother, Dr. Forrest Lowry, of Urbana.

John Charles Magill, M. D., St. Petersburg, Florida; Ohio State University College of Medicine, 1954; aged 42; died June 3. Records indicate that Dr. Magill left Ohio shortly after taking residency training in Columbus.

Anthony Carman Montani, M. D., Albuquerque, N. M.; University of Maryland School of Medicine and College of Physicians and Surgeons, 1925; aged 72; died August 22 in Phoenix, Arizona, at the home of his son; former member of the Ohio State Medical Association. Dr. Montani practiced for about 20 years in Youngstown. He left there in the 1940's and was director of a veterans hospital in Albuquerque until his retirement. His widow, son, and daughter survive.

Jacob A. Sargis, M. D., Cleveland; Ohio Medical University, Columbus, 1901; aged 94; died August 24. Dr. Sargis was born in Persia and first came to this country in 1893. He went back to his native country to practice medicine but retained his U. S. citizenship and returned to America during the early years of World War I. He practiced on the West Side of the Cleveland area, retiring only a few years ago. Dr. Harold T. Sargis is one of three sons who survive in addition to a daughter.

Lillian Posch Turner, M. D., Springfield; Ohio State University College of Medicine, 1935; aged 57; died August 8; member of the Ohio State Medical Association, and the American Medical Association. Dr. Turner practiced for many years in Springfield, formerly in association with her late husband, Dr. Ray M. Turner who died in April, 1964. Dr. Ray Turner was formerly on The Council of OSMA, representing the Second Councilor District. During the war years, Dr. Lillian Turner accompanied her husband on military tours, offering her professional services wherever needed. In Springfield she was school physician and a member of the local board of education. She was a member of the Methodist Church. Two sons are among survivors.

Cleveland Clinic Schedules Short Courses for Physicians

The Cleveland Clinic Educational Foundation has scheduled a number of short courses of interest to physicians, details on which may be obtained by writing Walter J. Zeiter, M. D., Director of Education, Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106. Following are titles of courses in coming months.

Upper Gastrointestinal Disease;
Clinical Aspects —
November 6 and 7.
Advances in Neurology —
January 8 and 9.
Surgical Problems of the Liver,
Biliary System, Pancreas, and Spleen —
January 15 and 16.
Cardiovascular and
Renal Clinical Pharmacology —
January 20 and 21.
General Practice —
February 5 and 6.
Controversies in Angiography —
February 12 and 13.
New Developments in Plastic Surgery —
February 19 and 20.

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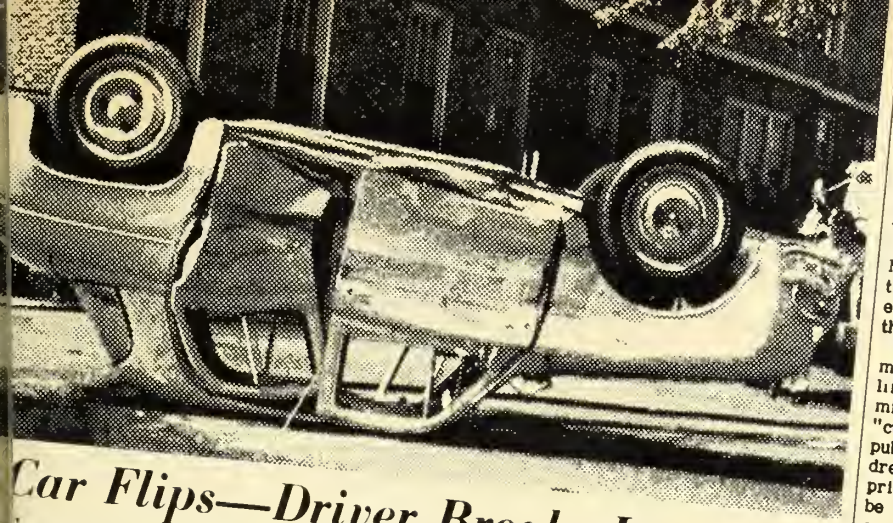
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Car Flips—Driver Breaks Leg

STAFF PHOTO

ept. 7. John P. Jones of ncurred a broken leg today

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its top

board h statemer issue, a tember t fications' ton dicta Althou made Mo down by a ter shar flat obje was pass Board McCred tion" s' elimir the st. The c ment ca limit ra mile li "cut-of public dren priv be b or th schoo The so so rather

e's had enough excitement for one day.

r the patient who has been through an accident, the worry and xiety following the experience may actually heighten the per-ption of pain. This is why there's a classic ¼ grain *sedative* se of phenobarbital in Phenaphen with Codeine—*to take the rvous "edge" off,* so the rest of the formula can control the n more effectively.

henaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

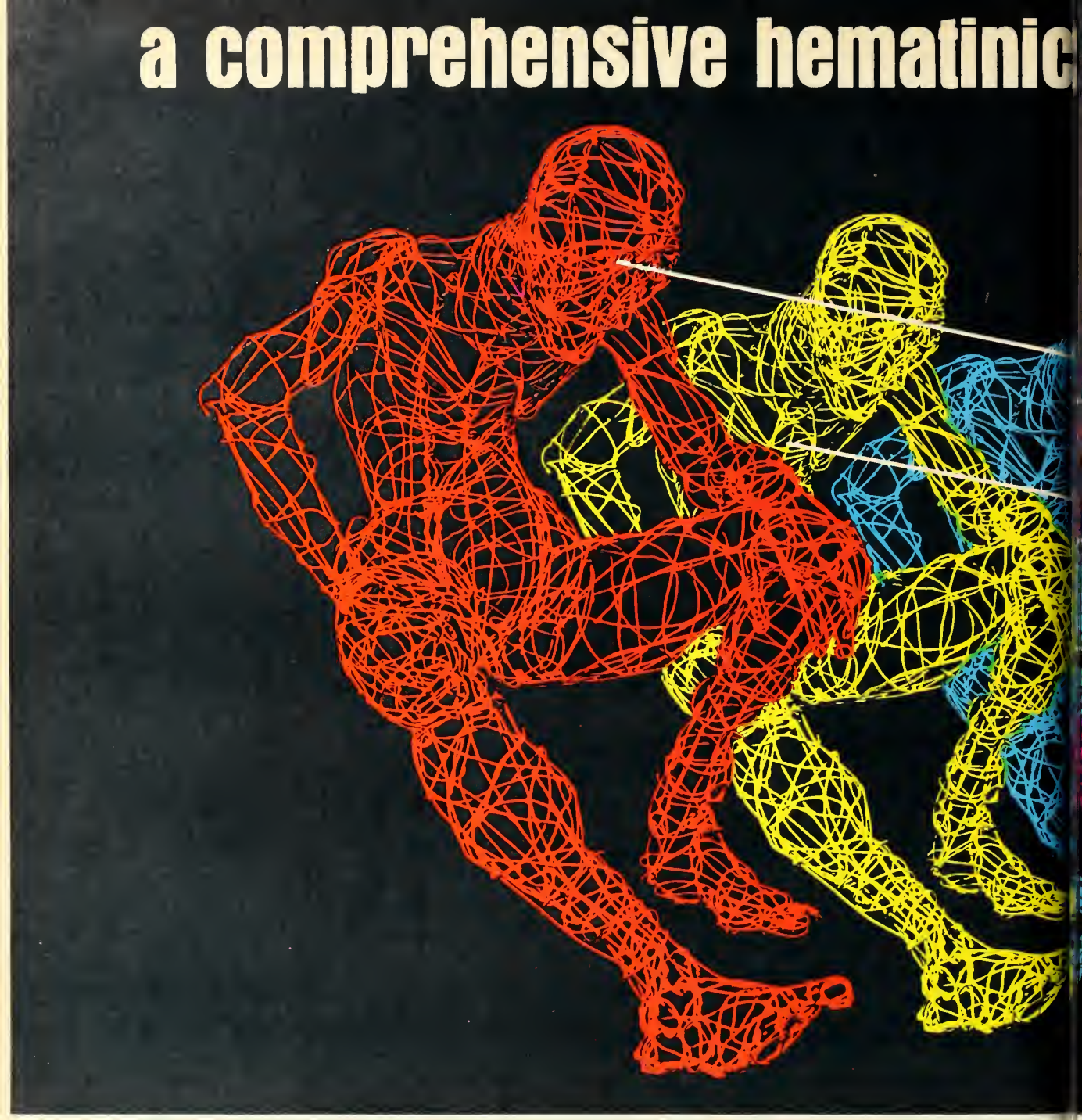
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Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A.H. ROBINS COMPANY
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a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires approp investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adeq vitamin B_{12} therapy may result in hematologic remission but rological progression. Adequate doses of vitamin B_{12} (parent or oral with potent intrinsic factor as in Trinsicon® [hema concentrate with intrinsic factor, Lilly]) usually prevent, he improve the neurological changes.

As with all preparations containing intrinsic factor, resist may develop in some cases of pernicious anemia to the pote tion of absorption of physiological doses of vitamin B_{12}. If re ance occurs, parenteral therapy, or oral therapy with so-c massive doses of vitamin B_{12}, may be necessary. No single men fits all cases, and the status of the patient observe follow-up is the final criterion for adequacy of therapy. Peri

You can treat combined deficiencies with

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—the multifactor hematinic



Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

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ial and laboratory studies are considered essential and are mmended.

se Reactions: In rare instances, iron in therapeutic doses ces gastro-intestinal reactions, such as diarrhea or consti-n. Reducing the dose and administering it with meals will ize these effects.

extremely rare instances, skin rash suggesting allergy has ed oral administration of liver-stomach material. Instances parent allergic sensitization have also been reported after dministration of folic acid.

ge: One Pulvule twice a day. (Two Pulvules daily produce a ard response in the average uncomplicated case of perni-anemia.)

Supplied: Pulvules Trinsicon® (hematinic concentrate with sic factor, Lilly), in bottles of 60 and 500. [032566]

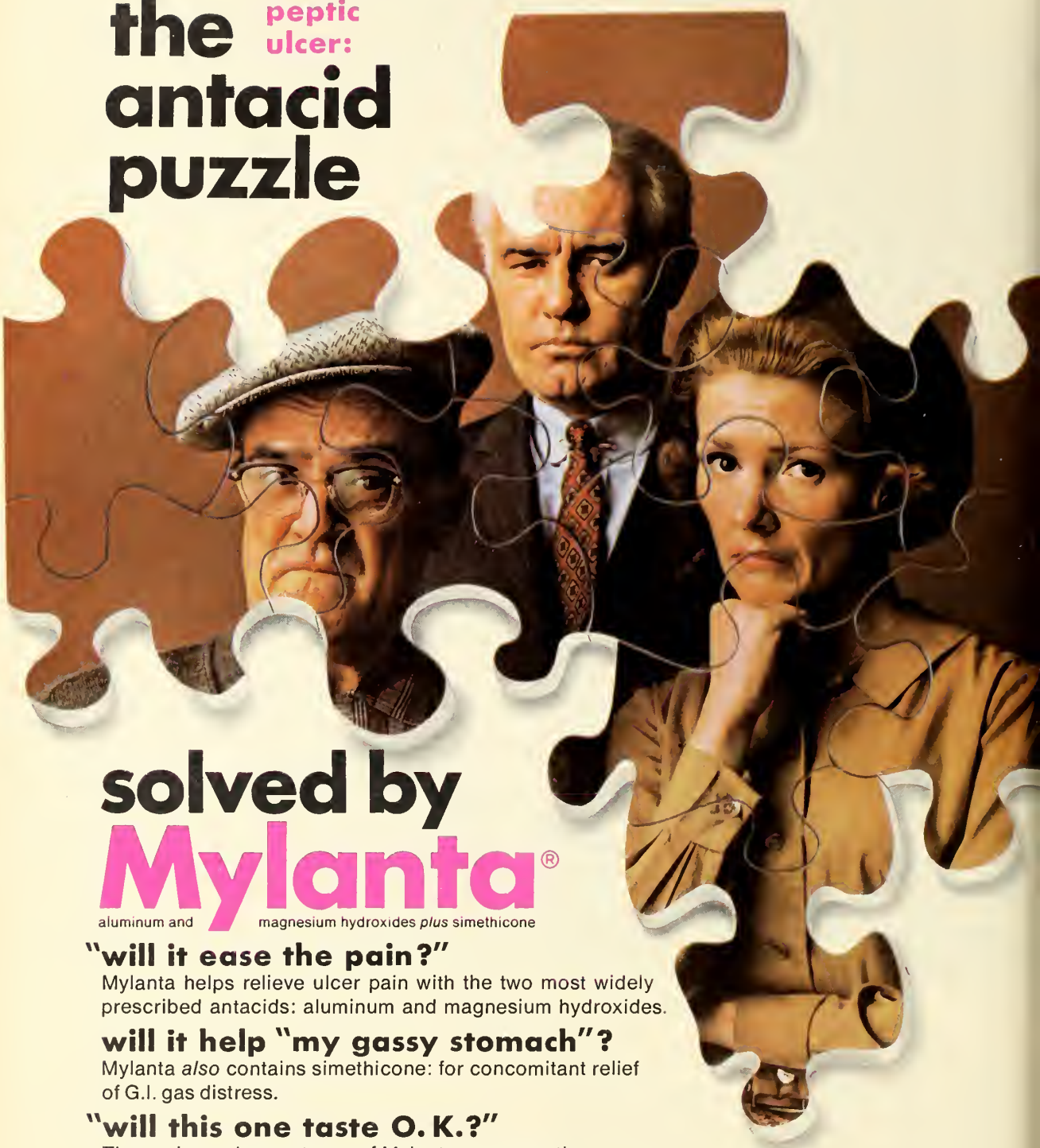
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Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Toledo Doctors Present Transparent Model



These Academy of Medicine doctors were the principals in the presentation of TAM, a transparent anatomical mannequin (shown in background), to the new Toledo Zoo Health and Science Theater at special ceremonies. From left are Drs. Eugene Ockuly, special adviser to the Zoo's Science Museum and its medical exhibits; William Blank, chairman of the Academy of Medicine's Foundation Fund through which the gift was made; Max Schnitker, chairman of the Maumee Valley Hospital Electro-Encephalograph Fund which financed the model; and Dr. John Kozy, Academy president.

Toledo Area Public to Benefit From Educational Mannequin

"TAM," a transparent model who explains the operation of the human body while her blood vessels and organs are illuminated automatically, made her formal entrance on the public service scene in Toledo at a special "coming out party" in her honor.

Donated by doctors of the Toledo area through their Academy of Medicine Foundation Fund and contributions to an Electro-Encephalograph Fund at Maumee Valley Hospital, the $15,000 figure has been placed in a new Health and Science Theater at the Toledo Zoo.

At presentation ceremonies, Drs. John Kozy, Max Schnitker and William Blank pointed out to guests that "TAM" (Transparent Anatomical Mannequin) represents a major public service and the beginning of what doctors hope will be a series of contributions to public education.

Educators in particular were urged to use the model in their school programs. The model speaks for 20 minutes through a tape recording and utilizes intricate lighting to tell the story of the human body and its functions.

Dr. Schnitker, chairman of the Electro-Encephalograph Fund which provided the financing, said it was a dream of many doctors to purchase such an educational medium ever since an anatomical model was seen at the Chicago World's Fair in the early 1930's.

Dr. Kozy, Academy president, praised the work of 12 doctors who combined their efforts to raise the funds and coordinate other efforts to make TAM a reality.

Dr. Blank, chairman of the Academy's Foundation

Fund, predicted that more than half of the Zoo's 800,000 visitors each year will see and hear TAM.

A "birth certificate," authenticating TAM's creation in Chicago and other data, was presented to Philip Skeldon, Zoo director.

Doctors, educators, health organization leaders, and others attended the open house in the Zoo Science Museum. The new theater seats 50. The "TAM Show" runs every hour on the hour.

More than four years of research went into TAM's construction. The model represents an initial investment of $100,000 by the Chicago firm.

The Toledo-owned model is one of four of that particular model in the country.

Activities of County Societies...

CHAMPAIGN

Dr. Mark Houston, attending physician at the Champaign County Home for 58 years, was honored by county physicians when a portrait of him was placed in the Champaign County Nursing Home.

The presentation was made by Dr. Isador Miller representing the Champaign County Medical Society.

Dr. Miller said, in presenting the portrait to Champaign County Commissioner William Bauer, "For 58 years Dr. Houston has looked after and cared for these patients. Fifty-eight years of outstanding and distinguished service! This deserves recognition."

Dr. Houston has served the nursing home since 1910. In 1913 he led a movement to establish a hospital at the site. He was also a leader in adding a new wing to the county hospital in 1931. When his service to the nursing home began, some of the present patients were yet unborn.—Urbana Daily Citizen.

HAMILTON

The annual meeting of the Academy of Medicine of Cincinnati was held on September 12 in the Daniel Drake Auditorium of the Academy headquarters, 322 Broadway. At that time Dr. William R. Culbertson was installed as president and gave the presidential address. Other officers, named to their respective offices at the May election, were introduced. They are Dr. Robert S. Heidt, president-elect; Dr. Ambrose H. Clement, secretary; Dr. Carl G. Thompson, treasurer; Dr. Stephen P. Hogg, and Dr. Milton W. Gwinner, trustees; and Dr. Harold Schiro, councilman-at-large.

The Academy recently released a brochure listing meeting dates, topics, and principal speakers for the 1968-1969 season. Coming program features are the following:

October 15—"The Diagnosis and Management of Central Nervous System Infections"—Paul F. Wehrle, M. D., professor of pediatrics, University of Southern California. This will be a joint meeting of the Academy of Medicine, the Cincinnati Pediatric Society, Cincinnati Obstetrical and Gynecological Society, and the Southwestern Ohio Society of Family Physicians.

November 19 - Panel Discussion on the topic "Hallucinogenic Drugs; A Local and National Problem"; Moderator, Daniel X. Freedman, M. D., professor and chairman, Department of Psychiatry, University of Chicago; Panelists—Otto G. Heinecke, director, Bureau of Drug Abuse Control; Richard E. Bibb, M. D., assistant professor and associate director, Central Psychiatric Clinic. This will be a joint meeting with the Cincinnati Society of Neurology and Psychiatry.

LORAIN

A feature of the early September meeting of the Lorain County Medical Society was presentation of scholarships to local student winners of competition.

Scholarships totaling $2,500 were awarded to 11 Lorain County area students studying for careers in the health professions by the Lorain County Medical Foundation.

The recipients were interviewed by a screening committee and were chosen over 36 other applicants.

Application forms for Medical Foundation scholarships will be available again next spring at the Medical Foundation, 428 West Ave., and from high school counselors.

MAHONING

For the 17th successive year the Mahoning County Medical Society sponsored the medical health tent at the Canfield Fair, August 29 through September 2.

Twenty-three exhibitors took part in the health display, including the Medical Society, the Auxiliary, and the Academy of General Practice.

Other exhibitors included the Society for the Blind, Blue Cross, the Cancer Society, the Cerebral Palsy Association, the Cystic Fibrosis Association, the Corydon Palmer Dental Society, the Northeastern Ohio Pharmaceutical Association, the Hearing and Speech Center, the Heart Association, Kidney Foundation,

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Mental Health Association, Multiple Sclerosis Society, Muscular Dystrophy Association, National Foundation, Planned Parenthood, the Mahoning Valley Podiatry Society, American Red Cross, Youngstown Safety Council, the Veterinarian Association, and the Youngstown Hospital Association.

The Hospital exhibit was the largest exhibit in the tent. The medical society brought back the popular "Life Begins" exhibit.

Teams of physicians also helped man the first aid station at the fair.

Ruling Eases Taxes on Benefit Payments to "War Orphans"

Taxpaying parents and guardians of an estimated 42,000 dependents going to school under the War Orphans Educational Assistance Act will get preferred treatment for income tax purposes, the Veterans Administration announced.

Payments to "war orphans" are now regarded as scholarships and are not to be counted for income tax purposes in determining whether the dependent received more than half of his support from the taxpayer.

Under the law, "war orphans" (children of veterans who died or are permanently and totally disabled as a result of military service) are entitled to monthly benefits of $130 for full-time enrollment, smaller amounts for part-time.

According to the VA, a recent Internal Revenue Service ruling calling such payments "scholarships" reverses an earlier finding.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

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(Rosenthal)

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Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

Dr. Everett R. Thomas was the subject of a feature article in the *Youngstown Vindicator* on the occasion of his retirement as physician for the Youngstown public schools for 28 years. He retired from private practice as a pediatrician last January.

Have You Changed Your Address Recently?

If So

Please Notify the OSMA Office Immediately

So The Journal and Office Mail Will Come To You Without Delay

Woman's Auxiliary Highlights...

By MRS. ROBERT E. PUMPHREY, Chairman, Publicity Committee

3055 Big Hill Road, Dayton 45419

Auxiliary Makes Important Plans — Involvement Is the Keynote — In the 1968 General Elections — In Issues at Home — In AMA-ERF Fund Raising — In Health and Education Programs —

PEOPLE ALL OVER THE COUNTRY are talking of politics and developing opinions regarding the November 8 General Elections. More than ever before, this is a time of serious thinking, evaluating, and doing. It is a time of involvement for every citizen.

Voter Registration

Montgomery County Auxiliary has made an all out effort to reach every physician and each member of the family who is of voting age before September 25 to find out whether they were registered to vote. Two years ago personal contacts were made by phone —this year direct contact was made by mail.

"Plan now to work on election day", comes word from Mrs. C. C. Long, president WA-AMA. "Get friends and neighbors to the polls."

Campaign Special

Hamilton County, a real red, white, and blue group held a program on September 24 called "Get Aboard the Campaign Special." The speakers' platform was rigged to look like the caboose of a train. Speakers were Mrs. Clara Weisenborn, state senator of Ohio; John Gilligan, Democratic candidate for the U. S. Senate; William B. Saxbe, Republican candidate for the U. S. Senate; and chairmen of the Democratic and Republican organizations in Hamilton County — Earl T. Barnes, Republican, and Sidney Weil, Jr., Democratic cochairman.

The meeting was a political action workshop with the theme of "Know the P's and Q's of Politics" — participation, party, platform, precinct, qualifications, quest, quality.

Mrs. Harry L. Fry, state legislation chairman and member of the board of OMPAC, asks each county legislation chairman to give her the outcome of the local program on registration, the percentage registered, and whether the plan is to do a follow-up "Get Out the Vote" campaign. She suggests that each county plan a nonpartisan political rally or workshop in October and make certain all members are well informed on OMPAC-AMPAC. "Your opinion as a physician's wife can be valuable and convincing—however, to be an opinion maker we should READ, LISTEN, LEARN, THINK — then TALK. Contribute to the finances of your candidate or party. Early contributions are of great help. Don't worry if your contribution is small. It will be welcomed."

2nd Annual Hope Ball

Saturday, September 21, saw the 2nd annual Hope Ball sponsored by the Project Hope Committee of Columbus, held at the Grand Ballroom of the Sheraton Hotel. Distinguished guests were Dr. William B. Walsh, founder and director of Project Hope and His Excellency Oliver Weerasinghe, ambassador of Ceylon, and Mrs. Weerasinghe, of Washington, D. C.

Political Potpourri

Atwood Lodge will be the scene for a political program to be held by Stark County on October 15. Speaker will be Jim Seccombe.

Richland County held a "Join the Vote-In" luncheon meeting October 7.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President: Mrs. Malachi W. Sloan, II
415 Towerview Rd., Dayton 45429

President-Elect: Mrs. S. L. Meltzer
2442 Dorman Dr., Portsmouth 45662

First Vice-President: Mrs. Carl F. Goll
1001 Granard Parkway, Steubenville 43952

Recording Secretary: Mrs. C. L. Johnson
660 N. Detroit St., Kenton 43326

Second Vice-President: Mrs. J. Kenneth Potter
3113 Eastwick Dr., Cleveland 44118

Corresponding Secretary: Mrs. Roy Rounds
71 Greenhill Rd., Dayton 45405

Third Vice-President: Mrs. Harry L. Fry
810 Matson Pl., Apt. 703
Cincinnati 45204

Past President and Nominating Chairman:
Mrs. J. Paul Sauvageot
2443 Ridgewood Rd., Akron 44313

Treasurer: Mrs. Russell L. Wiessinger
2280 West Wayne St., Lima 45805

WA-AMA will hold a North Central Regional Workshop in St. Louis October 14-15 at the Bel Air East Hotel. Those from Ohio attending will be: Health Careers Chairman, Mrs. Andrew Zito; Community Health Service Chairman, Mrs. Elden Weckesser; Mental Health Chairman, Mrs. Daniel S. Wolff; AMA-ERF Chairman, Mrs. A. G. Steele, and Safety and Disaster Preparedness Chairman, Mrs. Karl Ulicny.

WA - OSMA Clipping Service

Mrs. Fry has been involved in many outstanding auxiliary activities over the years. One of her latest and very important ones is the organization in May of a clip-service, designed to keep the OSMA informed. About forty women in as many areas around the state are involved in doing this clipping service, which sends news of local candidates to the OSMA office.

Men who Propose and Pass Our Laws

In a recent News Letter for Leaders from WA-AMA, Mrs. Richard A. Sutter, editor, stated that besides the importance of the presidential election, it is a vital fact that 435 seats in the House of Representatives and about a third of the Senatorial seats will be decided. These are the men who propose and pass our laws that will decide the course this country is to follow for generations to come.

Program Magic

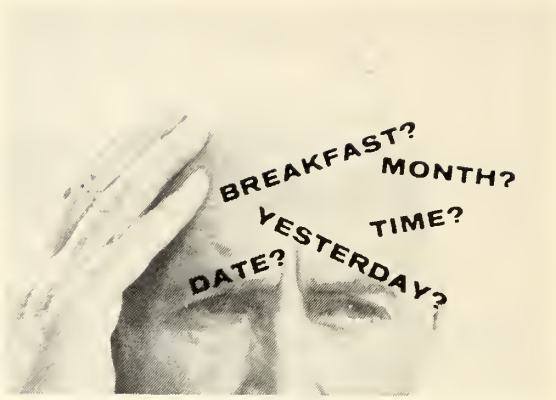
Mrs. S. L. Meltzer, OSMA Auxiliary president-elect and state program chairman, is enthusiastic about the theme for programs this year for the auxiliary and the community—PROGRAM MAGIC. She believes that "Our programs and projects can have a glamour all their own, via the special make-up of ACTION AND APPROACH." The goal is to make members *want* to participate. Emphasis is on ROUND TABLE DISCUSSIONS.

AMA-ERF Fund Raising

Word comes from National that all National, regional, and state county chairmen have been issued new AMA-ERF fund raising portfolios, containing new ideas and the most profitable ones from the past. THE DOCTOR'S WIFE rose bush is a new and exciting item (it would seem now, ladies, that there will have to be one also named THE DOCTOR. A new and bigger Christmas card selection is available. Golf balls for the "men in our lives" or us women retail from Faultless Rubber Company at $9.00 and $12.00 a dozen and have been big profit makers for AMA-ERF.

Toys for Children Overseas

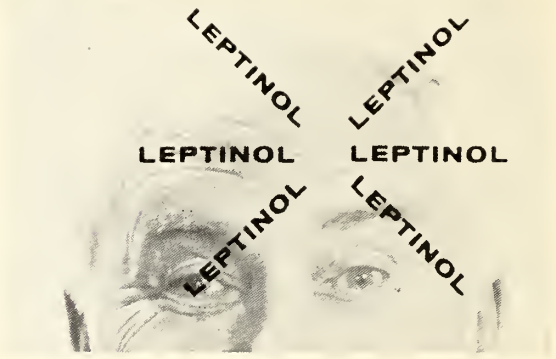
Now is the time for making Christmas toys for children overseas. "This is a project for youths and adults of all ages in your community—planting a



When elderly patients display symptoms of apathy, mental confusion, memory lapses...

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LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses. It is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day. Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.

Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

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DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
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DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67



smile on a face; awakening hope and love in the hearts of children — many of whom will be orphans."

There is no time to lose—toys must be in the hands of overseas sending agencies by November 1, 1968. Write to Mrs. Max Schnitker, 4130 Brookside Drive, Toledo 43606, or Mrs. E. L. Jung, 775 Oakwood Dr., Hamilton 45013, for detailed instructions for: nylon stocking dolls, doll blankets, crocheted toy balls and toy and exercise balls. DO IT NOW. World Medical Relief needs no more rolled bandages at the present as they are using those received. Sheets are needed.

Contributions to Direct Relief Foundation alone in 1967-1968 amounted to $381,000 after processing. World Medical Relief received over 60,000 pounds above the total for the previous year.

TV and Movie Violence Stand

The auxiliary is supporting the move to end TV and movie violence, which is a threat to the well-being of every person in our nation—especially our young people. *McCalls Magazine* recently pointed out that women can help stop the outpouring of violence and sordidness on our television screens and in our theaters. Auxiliaries can engage in programs directed at the source of decision on programming and content. Mrs. C. C. Long, national president WA-AMA, urges that top priority be given to this campaign.

Conferences and Workshops

WA-OSMA president, Mrs. Malachi Sloan, and president-elect, Mrs. Samuel Meltzer, will attend a national conference in Chicago November 29. They will also attend a national workshop in St. Louis October 14 and 15 at which time Mrs. J. Paul Sauvageot, past president, will play an important role.

Gems Baby Sitter Programs

GEMS stands for Good Emergency Mother Substitutes. The Ohio auxiliaries are sponsoring programs aimed at training baby sitters in safe child care. It is imperative that sitters learn protection for themselves and the children in their care. In Montgomery County alone over 2,600 people and teenagers have been shown the film "To a Baby Sitter" with a discussion period following.

The Ohio Lions Eye Research Foundation recently donated $24,000 for eye research at University Hospitals, Cleveland. At recent ceremonies, Richard Komjati, of Medina, district governor of Lions, and Dr. Marvin Resnick, of Akron, trustee of the Foundation, turned over the funds to Dr. Charles I. Thomas, director of ophthalmology at University Hospitals.

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A. No more than costive hematinics cost!

The anticostive hematinic is
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A tablet-a-day provides:

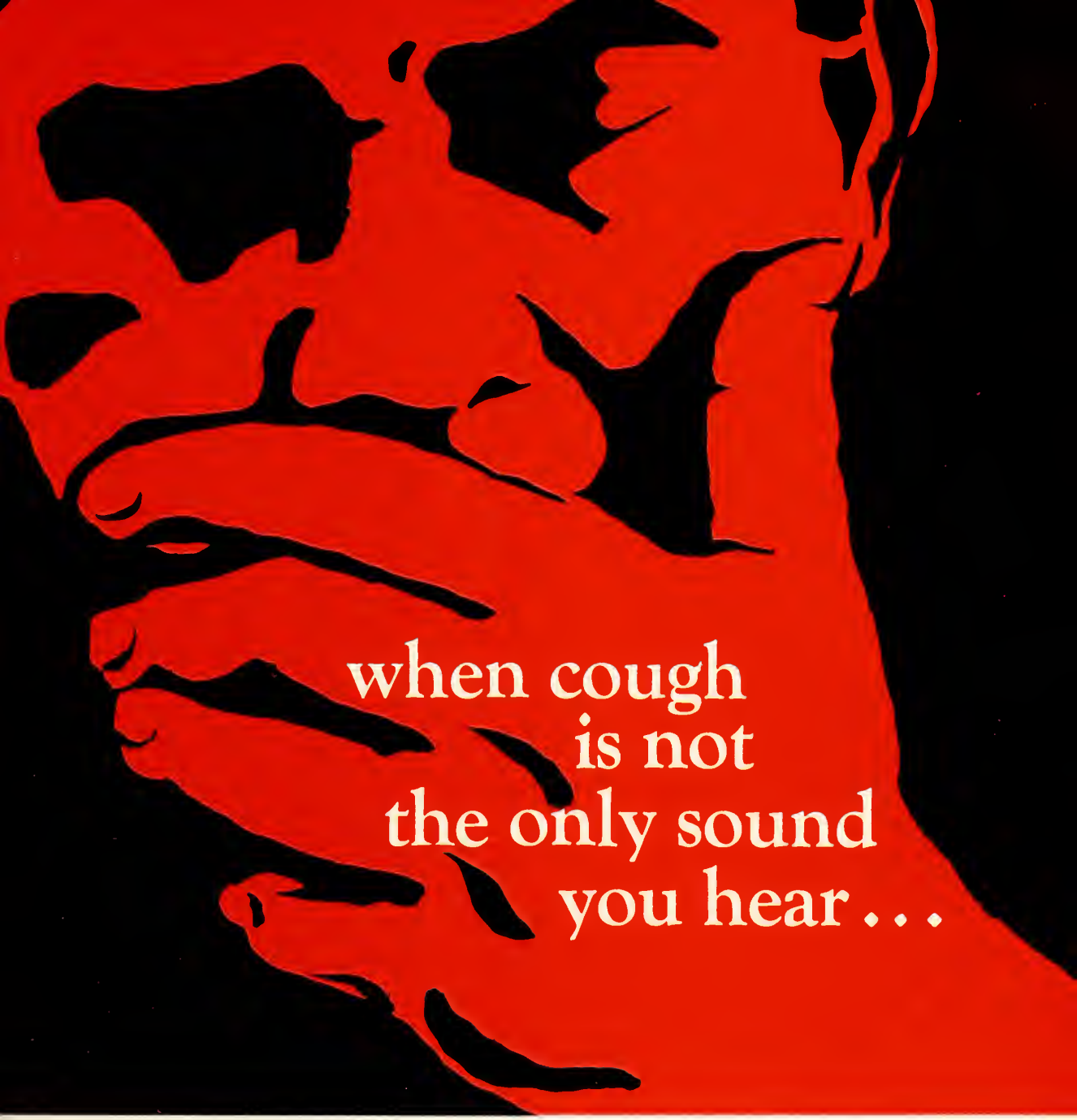
● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
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Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. Th following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reactic (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within th recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in female than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-16



Eli Lilly and Company
Indianapolis, Indiana 46206



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

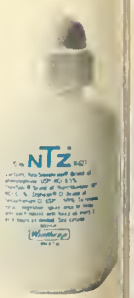
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Donald K. Martin, Former OSMA Executive Secretary, Dies

Donald K. Martin, former Executive Secretary of the Ohio State Medical Association, died in Columbus on September 3 at the age of 79.

A pioneer in lay medical organization work, he became Executive Secretary of the Ohio State Medical Association in 1919 when the late George V. Sheridan resigned from that post. In 1935 he resigned to accept appointment as Executive Secretary of the Ohio Manufacturers' Association, a position he held for many years. He was succeeded as OSMA Executive Secretary by Charles S. Nelson.

Mr. Martin was an attorney, member of the Ohio Bar Association, and a life member of the Ohio Trade Association Executives. Other affiliations included membership in the Woodsfield Masonic Lodge . A brother survives.

Annual Neurology PG Program Offered at Ohio State

On November 15, a one-day program "Diagnosis and Management of Epileptic Seizures" will be presented by the Ohio State University College of Medicine, Division of Neurology. Symptomatology, diagnosis, etiology, classification and management of epileptic seizures in children and adults, status epilepticus, and the EEG in epilepsy will be discussed.

Guest speakers will be Dr. Thomas W. Farmer, University of North Carolina, and Dr. Manuel R. Gomez, Mayo Clinic.

Additional information may be obtained from W. C. Wiederhold, M. D., chief of neurophysiology in the Division of Neurology, OSU, 410 West 10th Avenue, Columbus 43210.

Cincinnati House Staff Officers For Year Are Announced

The House Staff Association of the University of Cincinnati Medical Center — a group of 69 interns, 225 residents, and 45 fellows who work in the medical center complex — recently announced the election of its officers for 1968-1969.

Dr. Jonathan E. Rhoads, Jr., fourth year surgical resident, is the newly elected president. Other officers are Dr. Julian Ferholt, senior resident in psychiatry, first vice-president; Dr. David F. Sloan, first year resident in general surgery, second vice-president; Dr. Robert Nelson, chief resident in ophthalmology, third vice-president; Dr. Maryellen Davis, junior resident in psychiatry, secretary; and Dr. David Apple, senior resident in orthopaedic surgery, treasurer.



Annual Course in Ophthalmology Offered at Ohio State

The 12th Annual Postgraduate Course of the Department of Ophthalmology, Ohio State University College of Medicine, will be held on March 3 and 4, 1969. Subject of the course will be "Diseases of the Fundus." Among speakers will be Dr. Donald Gass, Miami, Florida; Dr. Bradley Straatsma, Los Angeles; Dr. Robert Watzke, Iowa City; and members of the OSU faculty.

Additional information may be obtained from William H. Havener, M. D., Department of Ophthalmology, 320 West 10th Avenue, Columbus 43210.

Annual Course in Nursing Offered By the Cleveland Clinic

The Cleveland Clinic Educational Foundation's third annual postgraduate course in nursing, "Update 1968," has been scheduled for October 16 and 17 at the Foundation's auditorium in Cleveland.

The two-day session will feature nine clinical sessions presented by doctors and nurses who are specialists in the medical topics to be explored.

Reservations can be made by writing to Educational Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, 44106.

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19 NOV 1968

The OHIO STATE MEDICAL Journal

Published By The Ohio State Medical Association

EMBER 1968
E 64 ★ NUMBER 11

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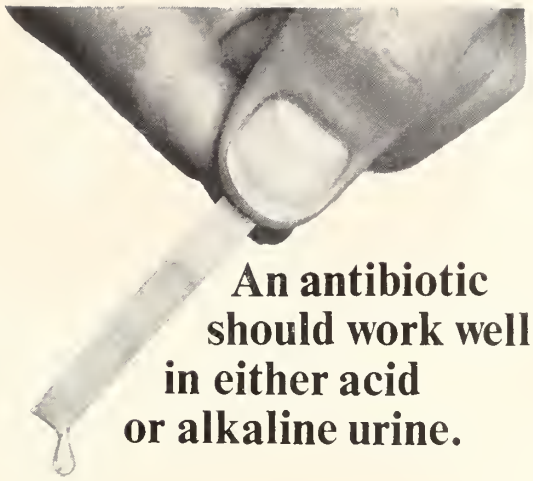
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

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DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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407-8



Statistical Study on Increasing Senior Citizen Population

The number of people aged 65 and older continues to increase rapidly in the United States. Estimates by the Bureau of the Census placed the total in July 1967 at a record 18.8 million — a gain of 2.2 million since the census taken in April 1960. Of this total, more than 17.3 million — or over nine tenths — were white, the proportion of whites in each age group being slightly higher for females than for males. It is expected that by 1975 the number of aged will increase to more than 21 million and by 1985 may reach 25 million.

Our elders are expected to account for a growing percentage of the population in the years to come, although their proportion will not increase as rapidly as in the past. Currently, those aged 65 and older make up about 9.5 per cent of the total population and it is anticipated that by 1985 the figure will rise to 10 per cent.

In the next few years, those 65-69 years of age will be the fastest growing segment of our aged population. Between 1967 and 1975, men and women in this age bracket are expected to increase by almost 15 per cent. In comparison, the increases are expected to be 10.5 per cent at ages 70-74 years and almost 12 per cent for those 75 years and older. In the following decade, persons 70-74 years old will experience the most rapid rate of growth — in excess of 20 per cent; those aged 75 and over will increase by 18 per cent, and those 65-69 years by more than 16 per cent.

At present, there are 2.6 million more elderly women than men — 10.7 million women as against 8.1 million men. In 1975 this difference will increase to 3.5 million and by 1985 to more than 4.6 million. — Excerpt, *Metropolitan Life*.

Speak at Radiology Meeting

The program of the recent American Roentgen Ray Society annual meeting in New Orleans showed presentation of the following papers by Ohio physicians indicated:

Some interesting Manifestations of the Stenotic Phase of Regional Enteritis" — Dr. Sidney W. Nelson, Columbus.

"Pitfalls in the Diagnosis of Selective Coronary Arteriograms" — Drs. Donald S. Linton and Cathel A. Macleod, Cleveland.

"Arteriography of Renal Neoplasms" — Drs. Ralph J. Alfidi, W. M. Gill, and H. J. Klein, Cleveland.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

or headache, a sovereign remedy was wear a snakeskin round one's head.



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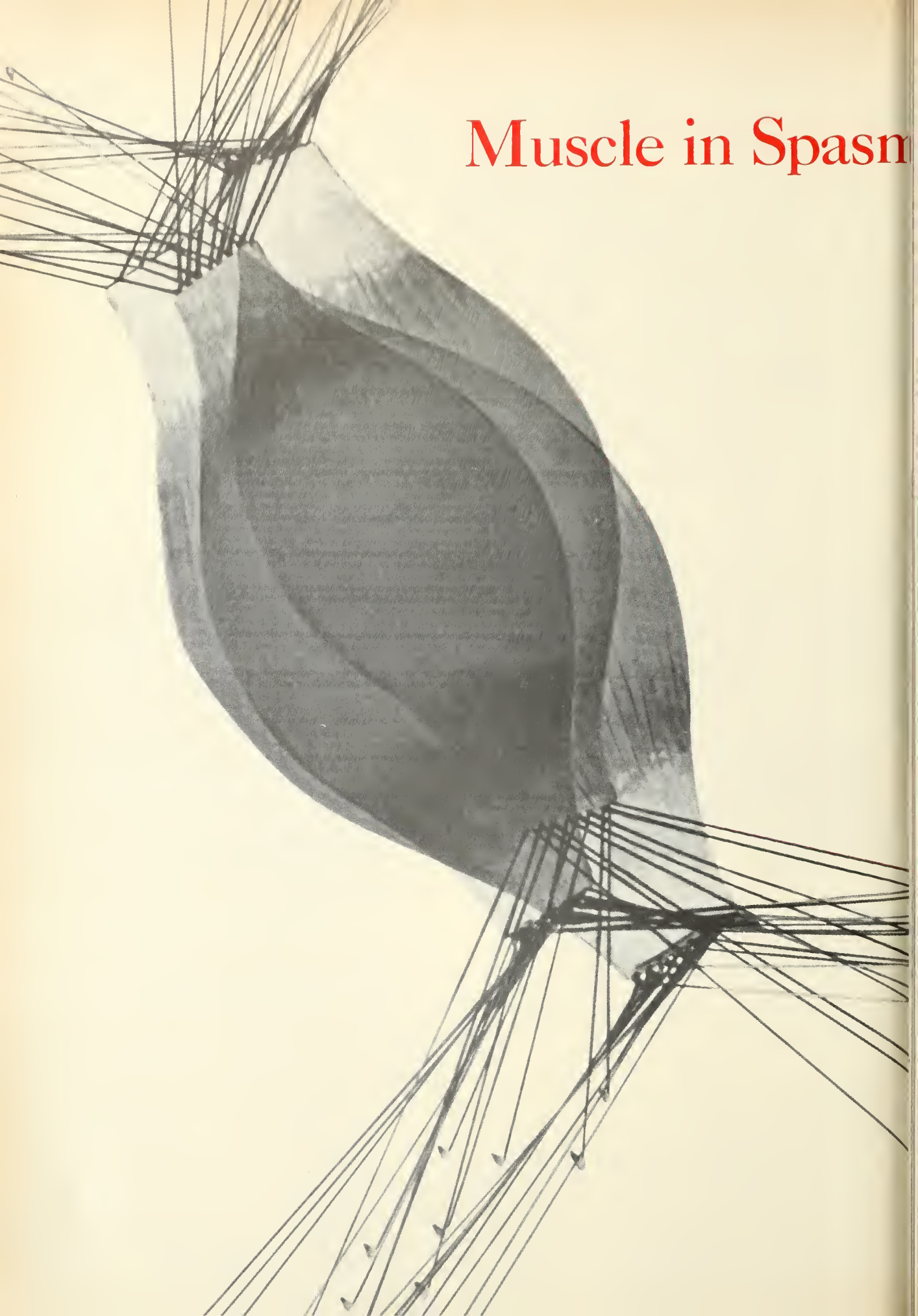
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The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

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Indications: Hypertension ond mony types of edemo involving retention of solt ond woter.

Contraindications: Hypersensitivity ond most cases of severe renal or hepotic diseases.

Warning: With the odministrotion of enteric-coated potassium supplements, which should be used only when adequote dietory supplementotion is not proctical, the possibility of small-bowel lesions (obstruction, hemorrhoge, ond perforotion) should be kept in mind. Surgery for these lesions hos been required frequently and deoths hove occurred. Discontinue enteric-cooted potossium supplements immediotely if obdominal poin, distention, nouseo, vomiting, or gostrointestinol bleeding occur.

Use with coution in pregnant women ond nursing mothers since the drug moy cross the plocental borrier ond oppeor in cord blood ond since thiozides moy oppear in breost milk. The drug moy result in fetol or neonotol jaundice, thrombocytopenia, and possibly other adverse reoctions which hove occurred in the adult. When used in women of childbeoring oge, bolonce benefits of drug ogoinst possible hozards to fetus.

Precautions: Antihypertensive therapy with this drug should olwoys be initioted coutiously in postsympothectomy patients and in potients receiving gonglionic blocking ogents, other potent ontihypertensive drugs or curore. Reduce dosoge of concomitant ontihypertensive ogents by ot leost one-half. Becouse of the possibility of progression of renal damoge, periodic determinotion of the BUN is indicoted. Discontinue if the BUN rises or liver dysfunction is aggrovoted. Hepotic como moy be precipitated.

Electrolyte imbolonce, sodium and/or potossium depletion moy occur. If potossium depletion should occur during therapy, the drug should be discontinued ond potassium supplements given, provided the potient does not hove marked oligurio.

Toke speciol core in cirrhosis or severe ischemic heort diseose ond in potients receiving corticosteroids, ACTH, or digitolis. Solt restriction is not recommended.

Adverse Reactions: Nouseo, gostric irritotion, vomiting, onorexio, constipotion ond cromping, dizziness, weokness, restlessness, hyperglycemio, glycosurio, hyperuricemia, headache, muscle cromps, orthostotic hypotension, which moy be potentioted wher chlorthalidone is combined with barbiturotes, narcotics or olcohol, oplas onemio, leukopenio, thrombocytopenia, agronulocytosis, impotence, dysuria, tronsient myopio, skin rash urticaria, purpuro, necrotizing angiit ocute gout, ond poncreotitis when epigostric poin or unexploined G.I. symptoms develop after prolonged odministrotion. Other reactions reported with this closs of compounds include: joundice, xanthopsio, pares thesio, ond photosensitizotion.

Average Dosage: 50 or 100 mg. with breokfost daily or 100 mg. every oth doy.

Availability: White, single-scored tal lets of 100 mg. and oqua tablets of 5 mg., in bottles of 100 and 1000.

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For full details, please see the complete prescribing information.

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Ohioans Have Special Interest In Rural Health Conference

Ohio's status as an agricultural state and its heavy nonurban population combine to make rural health an ever present area of concern for physicians. Of particular interest in the spring national rural health conference.

The 22nd National Conference on Rural Health will be held at the Philadelphia Marriott Motor Hotel, Philadelphia, Pa., on March 21 and 22. Program features begin at 9:00 A.M. on Friday, March 21, and the conference continues through Saturday morning.

The theme is "Meeting Rural Health Needs in Our Changing Times." The purpose is to explore new needs and report on new developments in: planning for health services in rural areas; health education for healthful living; systematic approach to emergency medical services; health manpower — physician, dentist, veterinarian, nurse, and allied health personnel; changing role of the nurse; migrant health program; mental health facilities; and the new role of the family physician.

The Conference is sponsored by the American Medical Association and numerous other organizations interested in rural health.

Ohio, which has pioneered in organization of rural health activities, is fortunate to have a member on the AMA Rural Health Council. He is Dr. Robert E. Reiheld, Orrville, who is also chairman of the OSMA Committee on Rural Health.

Details may be obtained from: Council on Rural Health, American Medical Association, 535 N. Dearborn Street, Chicago 60610; Bond L. Bible, Ph. D., Secretary.

American College of Physicians Schedules Short Courses

The American College of Physicians has scheduled a series of postgraduate courses for the 1968-1969 season in various parts of the country, two of them in Cincinnati. Details may be obtained from the college at 4200 Pine Street, Philadelphia, Pa. 19104.

"The Doctor: His Patient and the Illness" is the topic of a course scheduled at the University of Cincinnati College of Medicine, March 3-4. Drs. William Ransohoff and Paul H. Omstein are co-directors.

"Internal Medicine: Clinical Application of Current Concepts," is the topic of a course, also at the University of Cincinnati, June 9-13. Drs. Richard W. Vilter, and James F. Shieve are co-directors.

Some other courses are convenient for Ohio doctors. A program on "The Internist and Total Cancer Care" will be presented in Detroit, January 20-24, 1969; and "Modern Pathology for Internists" will be the topic in Pittsburgh, March 24-28.



THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

In Our Opinion

Comments on Current Economic, Social And Professional Matters

DRUG ABUSE, A FIELD IN WHICH THE INDIVIDUAL PHYSICIAN CAN HELP

Drug abuse control is "impossible without public education and scientific research, as well as law enforcement. . . . The failure of any one of the three will mean the failure of all." The quoted words are those of U. S. Attorney General Ramsey Clark, who spoke in Washington to representatives of some 55 medical, pharmaceutical, labor, public health, and voluntary organizations interested in the drug abuse field.

The Ohio State Medical Association as well as the American Medical Association and many other branches of organized medicine are putting their forces behind research and education in this field. On the other hand, no amount of educational effort can filter down to the grass roots unless local groups and local people assume the final responsibility.

A recent statement on this subject, jointly issued by the National Academy of Sciences and the AMA concluded with these words: "In the final analysis, an informed citizenry is the most effective deterrent of all."

This is an all-important field for the individual physician who is especially concerned with the future of young people. Talks before youth and parent groups; contacts with school authorities and civic clubs; close cooperation with law enforcement agencies, are areas in which the individual physician can make his influence felt. The OSMA Committee on Mental Health is ready to provide materials and help local physicians who are interested in this field.

A JOB FOR PRACTICING PHYSICIANS AS WELL AS MEDICAL EDUCATORS

". . . . The health care industry has now grown to such proportions, and the many problems of the world having close relation to the health of mankind have also grown so great, that a new era of nonprofessional influence on health care has developed.

"If we in the profession are to continue the leadership role in determining what health care shall be, it will be necessary for us to alter our previous course in many respects. It is mandatory that we give up many of the previously cherished ways of medical education and practice in favor of greater efficiency, in favor of modern ways of dealing with the vast amounts of accumulating knowledge, and most importantly, that new and imaginative ways be devised for increasing the training of health manpower to meet the requirements of a burgeoning population in this country."

Those are quoted words of Dr. Kenneth E. Penrod, provost of the Indiana University Medical Center, given at the University of Cincinnati College of Medicine convocation ceremonies. His warning that "if we in the profession are to continue the leadership role in determining what health care shall be . . ." is timely and thought provoking.

It is encouraging that nonprofessionals are taking an increasing interest in health care, but disaster looms if the medical profession defaults on leadership in its own area of responsibility.

Professional leadership begins with the student. Development of that leadership is a task that deserves full cooperation between medical educators and physicians in every branch of practice.

AMERICAN HEALTH CARE AND PROFESSIONAL PLANNING

The time has come to stop pushing the panic button on the subject of American health and health care.

Too frequently do we read the words of gloom, doom, and impending catastrophe. Every time we pick up a newspaper or magazine we are confronted with a "breakdown" or "crisis" in our entire system of health care . . . in health manpower . . . in the costs of health care . . . in the organization and delivery of health services . . . in the quality of health care . . . and so on, ad infinitum.

Those are words of Dr. Milford O. Rouse, Immediate Past President of the American Medical Association, as quoted in a national health organization publication. He continues:

Certain, as all knowledgeable, thoughtful people would admit, there are some inadequacies and inequities in our health care system. But never before has there been a clearer recognition of the problems



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The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

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☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vaseular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endartereetomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliae, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

themselves and the need for concerted, vigorous, long-range planning to solve these problems.

I believe the time has come to emphasize faith, hope, and potentiality — faith in the vitality and demonstrated accomplishment of our voluntary health care system . . . faith in this system's great potential for future progress . . . faith in the multiple strengths and resources which are available in this country.

In our opinion, Dr. Rouse's point is well taken. "The need for concerted, vigorous, long-range planning" is the crying need of the day. There is a growing responsibility — a public demand, if you please — for the medical profession to project itself into the grass roots of every planning program where the art of medicine and the protection of public health is concerned.

JOURNAL OF THE AMA ENDS CONFUSION IN PAGINATION

Beginning with the issue of September 30, *The Journal of the American Medical Association* began numbering its pages consecutively, discontinuing the former double pagination system.

Under the old system the advertising pages (which were interspersed with a great deal of valuable text) were numbered beginning with page one for each issue, the numbers being in light face type. The scientific pages were numbered beginning with page one for each volume (13 issues to a volume), the numbers being in bold face type. Consternation faced many a reader who used the index at the end of each volume. A page number alone referred to the scientific section; a bold face number and light face number separated by a colon referred to the "advertising" pages.

Congratulations to *JAMA* on changing to a single pagination system, much more convenient for readers. Incidentally, *The Ohio State Medical Journal* has always stuck to the single pagination, beginning page one in the January issue each year and progressing through to the last page of the December issue.

Dr. James A. Dickson, pioneer orthopedic surgeon, was honored recently at a ceremony in the Cleveland Clinic Education Building. A portrait, presented by practicing orthopedic surgeons he trained, was unveiled. A seminar room was dedicated in his honor, complete with plaque describing Dr. Dickson as "Surgeon, Teacher, and Humanitarian."

Dr. Harry L. Weaver, practitioner of long standing in the Alliance area, was honored at a meeting of the Kiwanis Club with a "This Is Your Life" program.

ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

uspected tetracycline-sensitive infection?

Vhile waiting for the results of the sensitivity test, tart the therapy likely to succeed...

though of course it can't replace routine nsitivity testing, your prescription for CHROMYCIN® V, in a way, provides the imate test of therapy under rigorous *in vivo* nditions.

Because ACHROMYCIN® V is effective in ating so many common infections—caused by ains of tetracycline-sensitive organisms—esn't *stat* dosage of this time-tested antibiotic ke good sense?

—Prescribing Information

ACHROMYCIN® V
TETRACYCLINE
Lederle

The price differential is inconsequential.



New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during September. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Belmont
Daniel J. Birmingham, Bellaire
Chit-Kui Jean, Bellaire
Theodore Harry Korthals, Bellaire
Joseph L. Williams, Bellaire

Cuyahoga
Jorge T. Froilan, Oberlin

Franklin
Raymond G. Cornell, Worthington
Marvin G. Green, Columbus
Ralph B. Norris, Columbus

Hamilton
Eldridge A. Baker, Cincinnati
Anardo C. Betances, Cincinnati
Kurt K. Bofinger, Cincinnati
Jack A. Brucher, Cincinnati
Frederic D. Burg, Cincinnati
Joan E. Carlson, Cincinnati
Robert H. Chess, Cincinnati
Richard E. Dean, Cincinnati
Philip H. Elliott, Jr., Cincinnati
Robert M. Glasgow, Cincinnati

Hamilton—contd.
Richard D. Longshore, Cincinnati
James F. Mack, Cincinnati
Bruce H. MacPherson, Cincinnati
Fawsy S. Mansour, Cincinnati
Charles E. McCarthy, Cincinnati
Venancio R. Quiambao, Cincinnati
Norman L. Rave, Cincinnati
Robert G. Slagle, Cincinnati
Theodore R. Stoner, Jr., Cincinnati
Theodore W. Striker, Cincinnati
Adriano C. Trinidad, Jr., Cincinnati
Dale R. Wiethe, Cincinnati

Jefferson
Antonio T. Lugay, Steubenville
Anthony V. Scurti, Smithfield

Ross
Ernest J. Parent, Chillicothe

Summit
Manuel Moreno-Rico, Cuyahoga Falls
Angelo Tirri, Akron

Farm Population Decreases While Accident Rate Increases

Accidents on American farms, other than those related to transportation, have increased significantly in recent years. The 1966 accidental death rate in the farm population was 18.7 per 100,000, or 15 per cent higher than in 1961. During this five-year period the farm population declined by more than a fifth, but the 2,200 fatalities reported in 1966 as having occurred in farm accidents represented a decrease of only about a tenth from the total recorded in 1961.

Tractor mishaps are the leading cause of fatal farm machinery injuries. According to a National Safety Council study, overturning accounts for a majority of the tractor accidents, but falls from tractors are also important. Most of the victims in tractor accidents are run over by the vehicle itself, or by the auxiliary machinery drawn by it.

Tractor injuries generally result from high speed and from lack of caution on hills, steep slopes, and other uneven ground; relatively few such accidents are attributable to mechanical failure or inclement weather. The severity of tractor injuries is indicated by the fact that three fourths of the fatally injured die within an hour of the accident.—Excerpt, *Metropolitan Life*.

★

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COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter

n the complex picture
f moderate to severe anxiety...



ere is a new reason
r prescribing Mellaril
(Thioridazine HCl)

fectiveness in
ixed anxiety-depression

ng recognized for its usefulness in the
atment of moderate to severe anxiety,
llaril is now also known to be effective
inst mixed anxiety-depression.

en the symptoms of anxiety states are
icult to sort out—even with the most careful
bing. The patient may manifest symptoms of
tation, restlessness, insomnia, somatic
plaints. But what of the depression that may
mixed in the total picture? It is reassuring
now that Mellaril may be prescribed—with
ng possibilities of success—when there is
iety alone or a mixture of anxiety
l depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170



Louie lost weeks with acute shoulder bursitis. That's a
of pain, stiffness and tenderness...and also a lot of fi
It might have been different with **Butazolidin® all**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forge

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(8) 46-070-B

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

The Divorced Depressive: "Forty; Forgotten

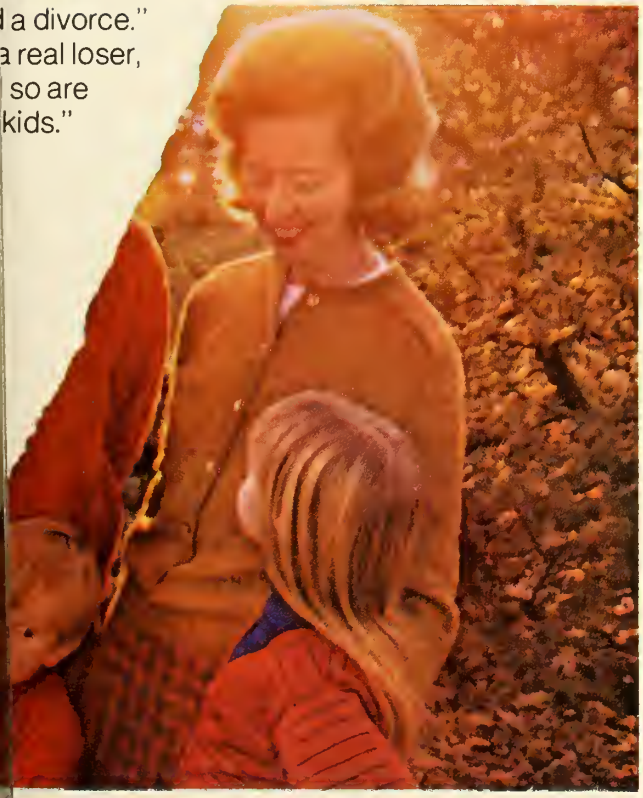
"Had a large wedding."
"Had a fine home and family."



TO-5757

Forlorn"

d a divorce."
a real loser,
so are
kids."



The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.[1]

When you diagnose depression, Tofranil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofranil can often help prevent relapse.

The use of Tofranil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofranil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

in depression

Tofranil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

Ways to Reduce Smoking Hazards Available in Pamphlet Form

Five ways to reduce the health risks of cigarette smoking are proposed in a new Public Health Service pamphlet recently issued.

Titled, "If You Must Smoke," the pamphlet was prepared by the National Clearinghouse for Smoking and Health, an agency of the PHS's Health Services and Mental Health Administration.

About a million and a half Americans swear off smoking each year, the pamphlet says, yet tens of millions continue to smoke, either because they are unable or unwilling to quit.

To help smokers "slow down" the harmful effects of smoking, the leaflet suggests five things they can do.

Excerpts of five positive steps recommended to lower one's intake of cigarette smoke are:

"1. **Choose a cigarette with less tar and nicotine** . . . . Learn the tar and nicotine content of your cigarette. . . . .

"2. **Don't smoke your cigarette all the way down.** No matter which cigarette you smoke, the most tar and nicotine is found in the last few puffs. . . .

"3. **Take fewer draws on each cigarette** . . . With practice, some people find they can substantially cut their actual smoking time without really missing it.

"4. **Reduce your inhaling.** Easier said than done? Perhaps. But remember it is the smoke which **enters your lungs** that does most of the damage. . . . .

"5. **Smoke fewer cigarettes per day** . . . Pick a time of day when you promise yourself not to smoke. It may be before breakfast. Or while driving to work. Or after a certain hour each evening. It's always easier to **postpone** a cigarette if you know you will be having one later. Maybe you're a pack-a-day smoker. Try buying your next pack an hour later each day. It may also help to carry your cigarettes in a different pocket. Or, at work, keep them in a drawer of your desk or in your locker — any place where you aren't able to reach for one automatically. The trick is to change the habit patterns you have established. Make a habit of asking yourself, 'Do I really want **this** cigarette?' before you light up. You may be surprised at how many cigarettes you smoke you don't really want."

Single copies of "If You Must Smoke," (PHS Publication No. 1786) are available without charge from the National Clearinghouse for Smoking and Health, 4040 North Fairfax Drive, Arlington, Virginia 22203. The pamphlet may be purchased in quantity from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, at five cents a copy or $2.50 per 100.

when aging brings anguish

LEPTINOL®

Improvement of mental alertness and awareness in the management of the senility syndrome requires a comforting environment, a stimulating dietary regimen and concomitant drug therapy.

LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses.

LEPTINOL® is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day.

Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.

Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

THE VALE CHEMICAL COMPANY INC.

VALE

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ALLENTOWN, PENNSYLVANIA 18102



Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg., chlorpheniramine maleate, 8 mg; and acetaminophen, 500 mg



DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

An anorectic will help her lose weight–
but can she keep it off?
You need more than a pill
(even ours) to do that!



That's why Abbott offers you a pill plus a program.

ABBOTT

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



FRONT SIDE

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



FRONT SIDE

The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444



Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

Ohio Areas Included in Studies On German Measles Vaccine

Children in nine communities in the United States, including the Cincinnati and Cleveland areas, are taking part in field trials of vaccine to prevent rubella, according to Dr. Dorland J. Davis, director of the National Institute of Allergy and Infectious Diseases. The NIAID is responsible for coordinating the government's efforts to avert a recurrence of the 1964-1965 epidemic which, institute spokesmen report, produced some 30,000 abnormal pregnancies.

Dr. Gilbert Schiff, of the University of Cincinnati College of Medicine, who has done extensive research in this field, is in charge of local trials in the Cincinnati area.

With the NIAID Vaccine Development Branch providing the research impetus, the full scale testing program — involving approximately 7,500 school children — will be aimed at further evaluation of the rubella vaccine's efficacy, a step to be taken before governmental licensing can be granted.

Dr. Schiff, University of Cincinnati associate professor of medicine and assistant professor of microbiology, notes the Cincinnati area field trials involve approximately 2000 children in southwestern Ohio and is being held in conjunction with local physicians.

The trials are part of long range plans to achieve an effective vaccine. For several years preliminary trials with small groups have been conducted by Dr. Schiff while he has continued research on vaccines in his laboratories in the Christ Hospital Institute of Medical Research, which is administered by the UC College of Medicine. Support for his work has come from varied sources, including the NIH and the National Foundation.

Other trial area centers are Vanderbilt University, Nashville, Tenn.; University of Southern California, Los Angeles; Case Western Reserve University, Cleveland; Tulane University, New Orleans, La.; State University of New York, at Buffalo and at Upstate Medical Center, Syracuse; U. S. Navy, Camp Lejeune, N. C.; and Yale University School of Medicine, New Haven, Conn.

Two of the pharmaceutical companies under contract to NIAID — Eli Lilly and Company, and Philips-Roxane Laboratories — produced the vaccine for the field trials. Independent production of HPV-77 derivatives and collaborative testing are also being carried out by Merck, Sharp and Dohme, of West Point, Pennsylvania.

REGIONAL MEDICAL PROGRAMS
A View from the Local Level

By NEIL C. ANDREWS, M.D., Coordinator, and CHARLES H. WHITE, Ph.D., Associate Director
Ohio State Regional Medical Program

REGIONAL MEDICAL PROGRAMS were created by Public Law 89-239, enacted by the Congress of the United States in 1965. During testimony about this program, a great deal of controversy and criticism arose over the original proposal to establish "centers of medical excellence." These centers would have been linked with satellite community hospitals to provide care for those patients with heart disease, cancer, and stroke. The concept of regional centers represented a serious threat to private practice in the minds of many physicians.

As a result of this criticism, only two of the original 33 recommendations of the President's Commission (the DeBakey Commission) on Heart Disease, Cancer, and Stroke were accepted by Congress. "Centers" became "Programs" for the promotion of education, research, and demonstrations of patient care for the defined categorical and related disease areas. Rather than providing money for construction of facilities, the revised "programs would establish cooperative arrangements among all health-field elements in a region."[1]

Regional Medical Programs represent an evolutionary partnership of the federal government with institutions, public and voluntary health agencies, hospitals, university medical centers, professional societies, physicians, nurses, and allied health personnel to combat those "killer diseases" that are responsible for 70 per cent of deaths in this nation. "Regional Medical Programs are attempting to reduce this percentage by reducing the time and space separating the latest research advance in these disease categories and the individuals who suffer from them."[2]

Voluntary Cooperation

Achieving this ambitious undertaking will require the voluntary cooperation of all health organizations and all medical and paramedical personnel within each region. Programs must be aimed and constructed to deliver the highest quality of patient care through the development and organization of facilities, the blending of science and service, and new emphases upon continued education and training. Without interfering with the present pattern of medical care, regionalization will allow the development of superior care by bridging this defined informational gap through improved communications and through total community involvement.

Regional Medical Programs are not designed to produce something from the top down. These programs must avoid telling physicians or hospitals or health agencies what they should want or what they should do. Flexibility is the hallmark of these programs, built upon local needs identified through local community involvement. The initiation of action must come from the local level rather than through state or national mandate.

The call for a readiness to change or improve when change is indicated is not an indictment of past or current practices and achievements. In fact, the opposite is true. The possibility for change rests on past progress and new needs are the product of past gains. Past accomplishments have created new demands.

As Regional Medical Programs grow closer to operational activities, complications arise from serious manpower limitations. Keen competition for manpower with leadership and planning capabilities place constraints on the rate of implementation of programs. It is essential that specific cooperative relationships be developed at all levels between Regional Medical Programs and other agencies. Competition, if allowed to grow, would be totally destructive.

Patient — Doctor — Community

The point of emphasis regarding Regional Medical Programs is not the success or failure of a federal program but an improved practice of medicine within the existing system. The improved care of the patient by his doctor in his community is the purpose of Regional Medical Programs. Private practitioners can be directly aided in their daily work without infringements upon professional freedom. In some respects, operational projects funded by Regional Medical Programs have represented a hastening in the timetable of medical advances. Most of the projects proposed would have been brought to fruition eventually through local efforts alone, but these advantages have probably been initiated years earlier through the cooperative arrangements fostered by Regional Medical Programs.

The first important step which must be taken is "the delineation of the real needs of the region and

the definition of approaches to meet these needs in terms of local resources and potential."[3]

A summary of Regional Medical Programs might be as follows:

The focus is on the patient with heart disease, cancer, stroke, and related diseases.

The mechanism is through cooperative activities of health professionals working within present arrangements for health services in a manner that will permit the best in modern medical care.

The emphasis is on local initiative and flexibility in this decision making.

The reasons for the urgency and priority of the program are the rapid scientific developments in the health field which have in the past only slowly been incorporated into patient care.[3, 4]

Four Programs in Ohio

Four Regional Medical Programs have been granted funds for planning activities in Ohio. These are listed below, including the names and addresses of Program Coordinators.

Ohio State Regional Medical Program
Neil C. Andrews, M. D.
410 West Tenth Avenue
Columbus Ohio 43210

Northwestern Ohio Regional Medical Program
C. Robert Tittle, Jr., M. D.
2313 Madison Avenue
Toledo, Ohio 43624

Northeast Ohio Regional Medical Program
Barry Decker, M. D.
10205 Carnegie Avenue
Cleveland, Ohio 44106

Ohio Valley Regional Medical Program
William McBeath, M. D.
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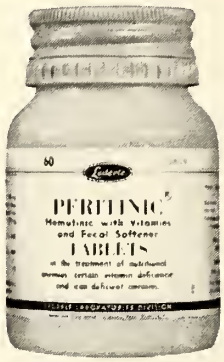
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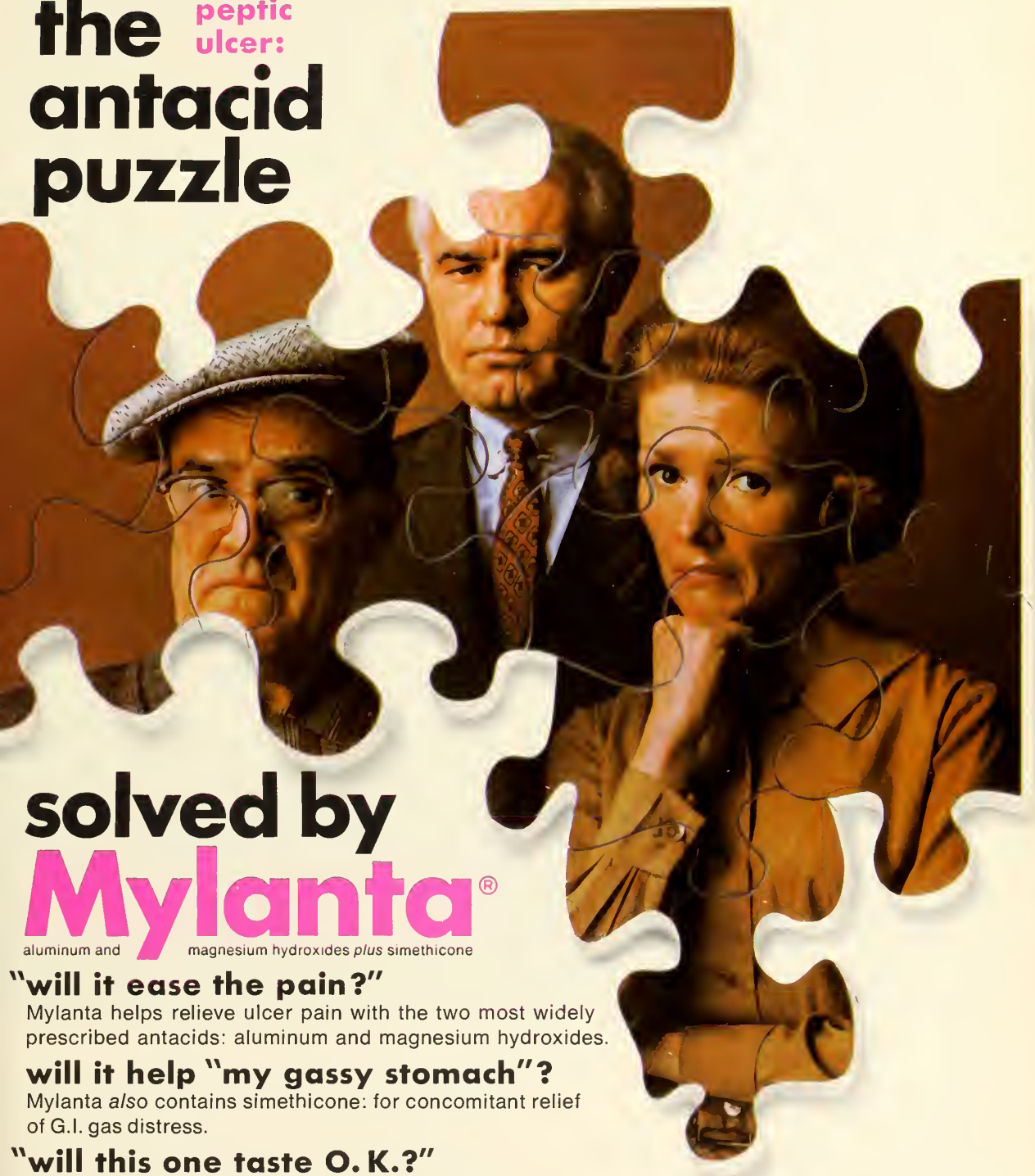
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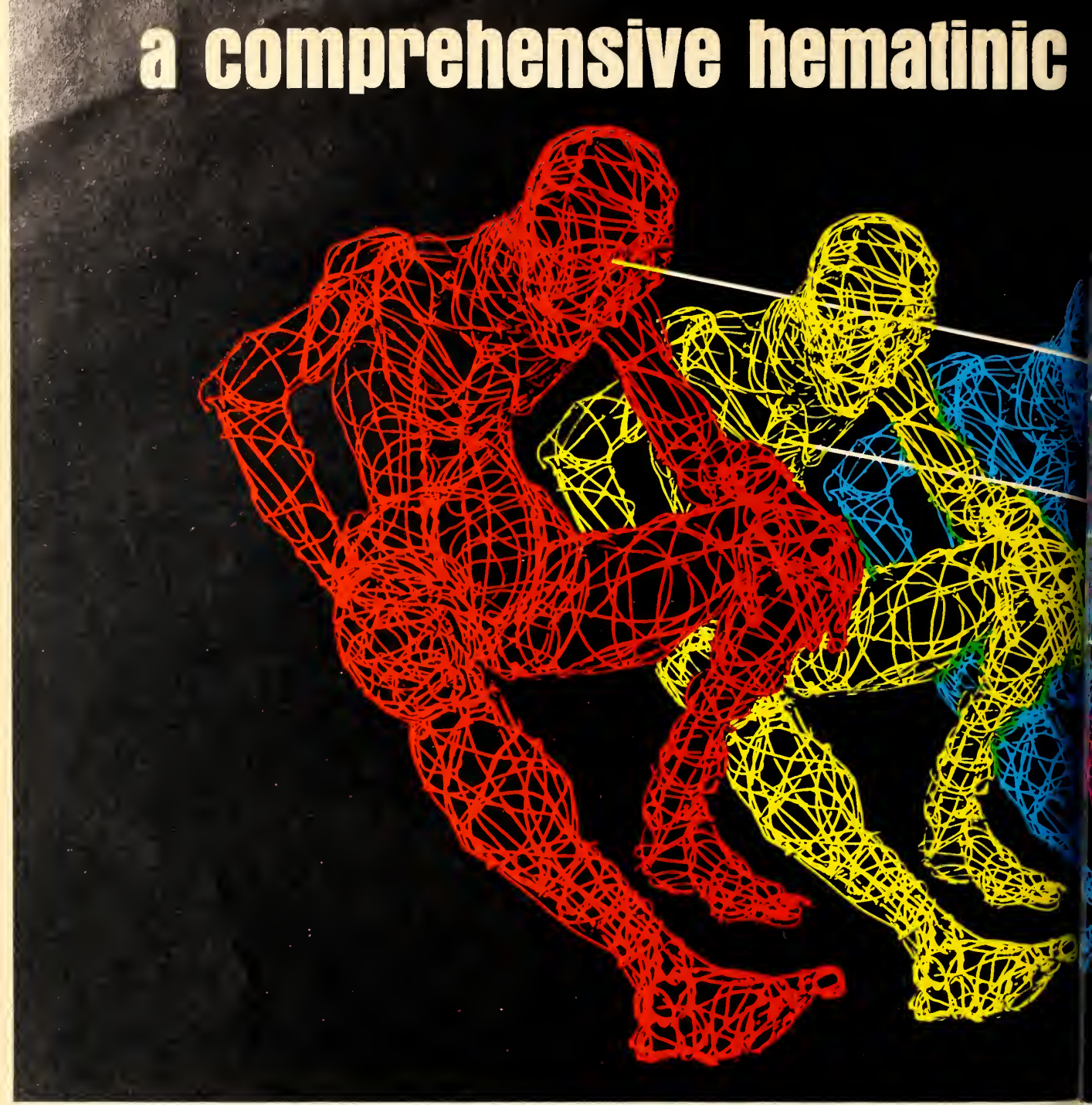
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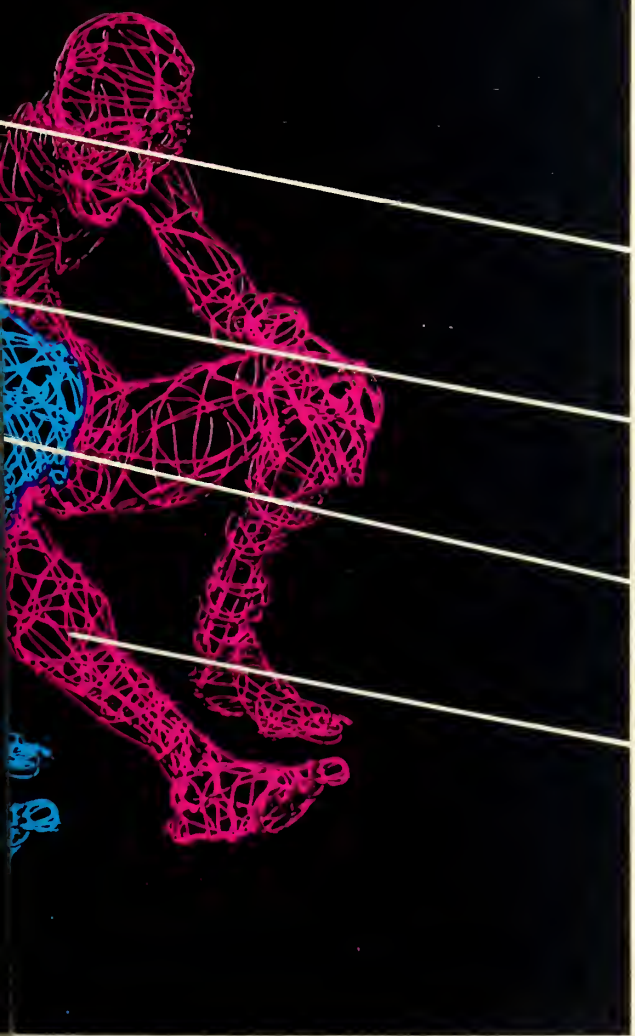
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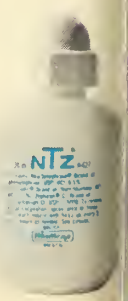
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The Stormy Career of G. S. Pattison A Colorful Anatomist

GEORGE R. L. GAUGHRAN, Ph. D.*

Tranquil Beginning

THE EARLY HISTORY of medical education in the United States was made by men of courage and determination. Among the pioneers in anatomy there were controversial figures, but none more colorful than Granville Sharp Pattison. He was born in Kelvin Grove, near Glasgow, Scotland in the year 1791. At age 17 he began the study of medicine in the private school of Allan Burns. Two years later he became a demonstrator of anatomy for Dr. Burns. In 1812 Pattison occupied the chair of physiology and surgery in The Andersonian Institute. The Institute was founded in 1796 by the Scottish naturalist, John Anderson, though the medical school was not begun until 1799.

Glasgow Period

The year 1813 ushered in a period of unrest which kept Pattison's career in a seemingly constant state of turmoil for most of the rest of his life. In December of that year, the body of a Mrs. M'Alister was taken from Ram's Horn Cemetery.† Earlier in the same year a number of large bags arrived at Glasgow supposedly containing cotton or linen rags. However, due to a delay in delivery and a suspicicious odor emanating from the contents, the bales were opened and found to be packed with dead bodies. This incident coupled with the stealing of Mrs. M'Alister's body so incensed the local residents that a warrant was issued to search every suspected anatomy room in the city. When they reached Pattison's lecture rooms in College Street, the young intrepid physician showed them about the dissecting rooms where they found nothing—until the fluid in a large macerating tub was poured off to expose certain human remains. "My God," exclaimed Alexander, the dentist, on examining the teeth, "these are part of the very set I made for her with mine own hands!" "And the finger," said one of her petrified relatives, "this is her finger, the very finger on which she wore her marriage ring. I know it well."

On this evidence Pattison, Andrew Russell, the lecturer on surgery, and two students (Robert Monro and John M'Lean) were taken into custody. In June 1814 the quartet was brought before the High Court of Justiciary of Edinburgh. Due to the fact that the remains which the officers had collected represented several different bodies, the defense was able to show that even though Mrs. M'Alister had had several children, on the testimony of a number of most eminent medical men, "the body produced by the officers was that of a virgin." With this twist in the evidence, the four defendants were acquitted.

To properly appreciate this incident one must place it in the proper context of the time. In the early nineteenth century Sir Astley Cooper appeared before the Select Committee in England and testified:[5] "for there is no person, let his situation in life be what it may, whom if I were disposed to dissect, I could not obtain." In 1829 the notorious Burke and Hare trial terminated in the hanging of the former.[6] Not until 1832 were the Acts for Regulating Schools of Anatomy passed in England.[3] Despite the rules, personal disapproval of human dissection, religious restrictions, and overwrought imaginations seriously hampered efforts to obtain human material through conventional channels for anatomical studies. It was not unnatural, therefore, in this particular period to find resurrectionists supplementing the cadaver supply for medical instruction.

A short time after this brush with the law, the record indicates that Pattison left Scotland in conse-

*Professor and Vice Chairman, Department of Anatomy, The Ohio State University College of Medicine.

†Accounts of this incident and the subsequent trial vary with the narrator.[1-4] I have taken the story related above from Mackenzie's Reminiscences of Glasgow.[1]

Based on a presentation at the 1966 Meeting of The Ohio Academy of Medical History. Submitted July 25, 1968.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

quence of a domestic difficulty with one of his colleagues. The domestic difficulty was with Dr. Andrew Ure, Professor of Chemistry and Pharmacy at The Andersonian Institute. Dr. Ure accused his wife of adultery, naming Pattison as the clandestine lover. This charge was brought before the Consistory Court of Edinburgh.[7] This court apparently was a religious rather than a civil court and had no provision for the accused to testify in his behalf. A letter was presented as evidence written by Mrs. Ure after she had left her husband and was living in obscure quarters in Falkirk under the name of Mrs. Campbell. It was addressed to Mr. Pattison and asked for financial assistance since she was already 5½ months pregnant. A servant for the Ures also reported suspicious relations between Mrs. Ure and Mr. Pattison. On the basis of the evidence presented, Dr. Ure was granted a divorce. Pattison, however, stated that Dr. Ure and his wife were so debased as to be capable of the most infamous of actions and further, that Mrs. Ure wrote a letter disclaiming all, but that her letter was too delicate to publish. In any event, there is no evidence to substantiate Pattison's claim of a letter discrediting her testimony. It is said that The Andersonian Institute completely exonerated Pattison.[4] Dr. Ure's character was certainly not above reproach. It was reported that Dr. Ure did not possess an enviable reputation in Glasgow and that he had fraudulently stolen his father's will in an attempt to defraud the family. Whether Mr. Pattison was actually guilty or innocent of the adultery charges, we shall never be quite sure, but, in any case, the notoriety led to his interest in emigrating from Scotland to a more favorable environment. In fact, Ball writes:[8] "so strong, however, was the public feeling, that Pattison had to emigrate to the United States." Since his brother, John Pattison, was already in the United States, it was natural that he would make efforts to settle there.

Philadelphia Period

Strangely enough it was during this very period that a tragic loss took place at the University of Pennsylvania Medical School. Coupled with this touch of fate was the coincidence that John Pattison resided in Philadelphia and appraised his brother of the circumstances and opportunities they presented. The tragedy referred to was the untimely death of the young and promising Dr. John Syng Dorsey, nephew of Dr. Physick. He had just been elected to fill the chair of anatomy made vacant by the death of Caspar Wistar and had barely delivered his first lecture when he died of a fever. Pattison, learning of the death from his brother, wrote to Dr. Dewees inquiring about the position in anatomy. Following this correspondence there occurred a concatenation of unfortunate events contributing in no small degree to Pattison's estrangement and bitterness. A letter written by Dr. Dewees to Pattison in April 1819 stated:[4] "As far then as a firm belief that you would succeed, (and



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the family's downed
Because the
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that belief founded on pretty certain data) will offer an inducement to pay us a visit, I have no hesitation to declare, that no question remains in my mind, that were you on the spot, your election would be certain. It is unquestionably the opinion of two of the most influential and best informed men here." The two men referred to were Dr. Nathaniel Chapman, Professor of Materia Medica at the University of Pennsylvania and Dr. Philip Syng Physick who occupied the Chair of Surgery at the same institution. The letter does sound extremely encouraging and, indeed it caused Mr. Pattison to show the letter to his friends in Edinburgh and ask their opinions. In Pattison's words:[9] "And as they were unanimously of the opinion that Dr. Dewees' letter was the equivalent to an appointment, I left that city the following morning for London, to take leave of my friends of the metropolis." Unfortunately, Drs. Physick and Chapman denied any knowledge of the letter but did remember having expressed the opinion to Dr. Dewees[10] "that if Mr. Pattison were present, and realized the extraordinary representations of his friends, he might succeed." Apparently, however, this was not meant to be transmitted to Pattison. As far as can be found in the record, only one friend, a Mr. Chauncey (through a letter from his brother) advised Pattison not to come to America since there seemed greater favor for an American for the position and, strangely enough, predicted Pattison's future reaction. The letter read:[9] "he could not and would not advise you to come, because he thought it very uncertain; and you would, (did you not obtain your object) naturally feel disgusted with the country, which he should feel sorry for." In any case, early in 1819, at about the age of 27, Pattison arrived in the United States armed with a most impressive array of recommendations (among them, one from Sir Astley Cooper) and an anatomical collection of over 1,000 specimens bequeathed to him by Allan Burns. The administrative transactions which had taken place in the interim remain a mystery even today. Dr. Physick, who occupied the Chair of Surgery and was an eminently successful surgeon, was transferred to the Chair of Anatomy. This is reported to have been against his wishes. Further, Dr. William Gibson was enticed from the University of Maryland to occupy the Chair of Surgery vacated by Dr. Physick. As one can imagine, on arriving in the United States and learning of this strange turn of events, Pattison was upset. It is said that he was offered a joint appointment but this he refused. He also rejected a Professorship in Anatomy offered to him by Transylvania University at Lexington, Kentucky. In a recent book on the history of the University of Pennsylvania Medical School, Corner[11] comments on the episode as follows: "Actually, behind the move lay a strange tangle of calumny, jealousy and professional politics." One cannot help but see the seeds of intrigue in these strange machinations. The net result, of course, was to immediately jeopardize Pattison's status in Philadelphia and to set the stage for further bitter quarrels with Gibson and Chapman. Since he found himself without a faculty position, Pattison set up independent lectures in anatomy and surgery and had a class of about 190 students. He claimed that when Chapman learned that his lectures were so popular, Chapman changed the time of his own lectures to conflict with Pattison's scheduled time, thus the students found it impossible to attend Pattison's lectures. To support Pattison's contention is the following statement concerning Chapman:[12] "A cleft palate, with its consequent indistinct utterance, robbed him of every charm as a teacher."

Maryland Period

In 1820, apparently to remove himself from an impossible situation, Pattison accepted the Chair of Surgery at the University of Maryland. This was the very same chair vacated by Dr. Gibson when he accepted the University of Pennsylvania position mentioned before. At Maryland, Pattison apparently supplied the necessary spark to revitalize the school. They not only purchased his collection of anatomical specimens for the sum of $8,000 but also constructed Prentice Hall to house the material.[13] Despite his obvious contribution to the improvement of the University of Maryland, his loss of the University of Pennsylvania appointment seemed to fulminate within his frame and in 1820 he initiated a chain of unilateral correspondence with Dr. Chapman, one of the men who opposed his Pennsylvania appointment. Having received no response did not help to soothe the delicate temperament of Pattison. Finally, a thoroughly irritated Pattison traveled to Philadelphia and posted Chapman as a "liar, a coward, and a scoundrel".[9] Chapman did not recognize the challenge by simply ignoring it. General Thomas Cadwalader, Chapman's brother-in-law, assumed the task of maintaining Chapman's honor and, somewhere in Delaware near New Castle about April 5, 1823, Pattison and Cadwalader met in a pistol duel.[14] The former was not injured but the latter received a wound in the wrist which he carried with him the rest of his life. Interestingly enough another duel is reported in the history of the University of Maryland—this between two students, one of whom was killed. During Pattison's career at Baltimore he was also accused of plagarism by Dr. William Gibson, Professor of Surgery at the University of Pennsylvania, and also by Dr. Nathanial Chapman, Professor of Theory and Practice.[15] In Pattison's behalf, it should be noted that when he was appraised of an earlier description of certain structures he had described as original, he acknowledged the priority. It is also appropriate to note that Gross[16] described Gibson as "vain, arrogant, and ill tempered." Pattison[4] himself had the last word with the following barb: "As Dr. Gibson has never brought forward a

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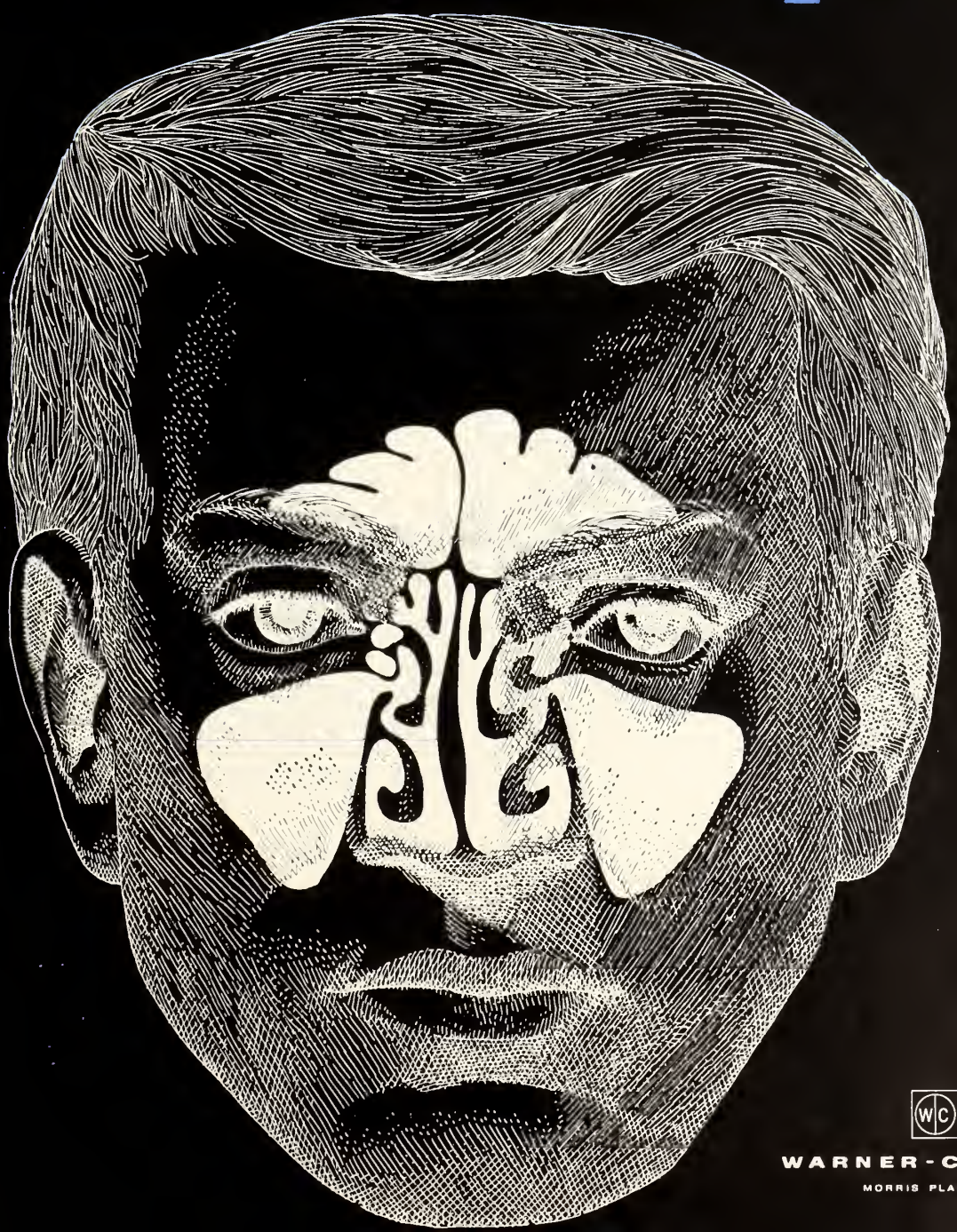
PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

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new thought or an original idea, on the subject of his profession, I have no power to test his discoveries."

London Period

Finally, on March 13, 1826, he resigned his position at Baltimore because of, according to the report, bad health and uncongeniality of climate and set sail for England where, in 1827, he received an appointment as Professor of Anatomy at the newly organized University of London. Here again he was haunted by troubles. His students were dissatisfied from the start and the situation became more and more critical with numerous articles appearing in the *Lancet* (1829-1831) to further promote the inflammation. An analysis of Pattison's problems by an earlier study[2] attributed them to: 1) his being a Scotchman coupled with an anti-Scot sentiment in London at the time; 2) having an Englishman as his demonstrator; and 3) being disliked by the editor (Wakley) of the *Lancet*. The *Biographisches Lexicon*[17] indicates that Pattison left his position at London because of quarrels with his demonstrator. Some of Pattison's students would not attend his lectures and they accused him of: 1) a speech impediment; 2) a monotonous voice; 3) defective grammar and knowledge of the classics; and 4) superficial anatomical knowledge. These accusations certainly do not reflect his teaching success at Baltimore and appear to be grossly exaggerated. Nevertheless, a Select Committee of the Council recommended his dismissal and, in July 1831, Pattison was dismissed.

Final Years

He returned to the United States and became Professor of Anatomy at Jefferson Medical College. Here he received an honorary M.D. degree in 1831. His subsequent career seems to have avoided the notoriety and conflict so prominent in the past. He spent an uneventful period of ten years at Jefferson and, in 1841, joined the founding of the Medical Department of the University of New York where he became Professor of General Descriptive and Surgical Anatomy. During this tranquil period he met and married a lady by the name of Mrs. Sharp and these last years of his life seem to have been one of married happiness coupled with vocational quietude. He is said to have enjoyed both art and music.[15] On November 12, 1851, at the age of 60, Dr. Pattison died from an obstruction of the common bile duct.

Despite the almost incessant controversy in which Dr. Pattison was embroiled, he found time to make a number of original contributions on such subjects as lithotomy, cholera, and parotid surgery. In addition, he edited American editions of Allan Burns' *Surgical Anatomy of the Head and Neck* (1823) and J. Cruveilhier's *The Anatomy of the Human Body* (1844). He was also one of the editors of *The American Medical Recorder* and authored *The Register and Library of Medical and Chirurgical Science*. He was a member of The Medico-Chirurgical Society of London and a Fellow of The Royal College of Surgeons. Dr. Pattison was a man of considerable talent, "intense feelings and strong prejudices."[18] He left us a modest legacy. As is so often the case, the truth as to the validity of the many charges made against him probably will never be known.

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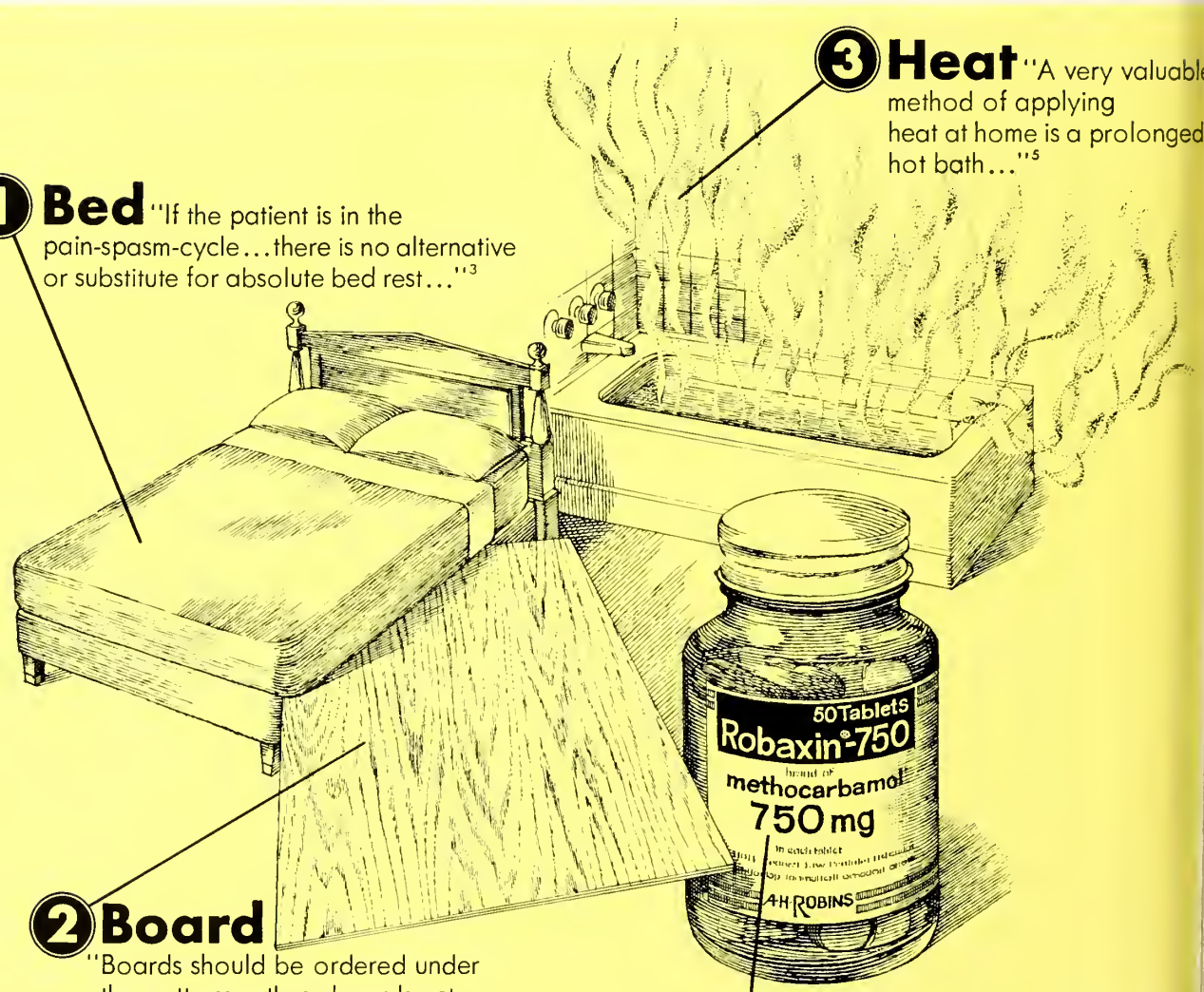
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The Community Practicing Physician as Teacher

EDWARD V. TURNER, M.D.

STUDENTS COME to medical school highly motivated to become doctors.[1] They come with many questions such as: What does it mean to be a doctor? What are the principles involved in the doctor-patient relationship? How do you deal with patients of different types? How can one learn to treat the patient as a whole person, and not just as a case of illness? What would it be like just to touch a patient? The clinical teacher can be of service to the medical student by helping him "to get, at the outset, an intimate knowledge of people and people's maladies," as Dr. Cushing said.[2]

Believing that experience with patients should begin as soon as the student starts medical school,[3] the faculty of the College of Medicine, Ohio State University offers a course entitled "Human Behavior and Human Relations (Introduction to the Patient)" in the first year of the curriculum.[4] Groups of six students meet with preceptors for two hours weekly. This session follows two hours of lecture-demonstration in which development of behavior, family planning, human sexuality, marriage, family life, interview technics and other matters are considered. Preceptors are members of the faculty of the College of Medicine in the departments of pediatrics, obstetrics-gynecology, psychiatry, internal medicine, physical medicine and rehabilitation, orthopaedics, and otolaryngology.

Different teachers teach differently, obviously. The following is a description of the activities of a group of which the author was the preceptor; it may provide ideas for others who are interested in undertaking a similar endeavor with medical students.

The Author

● **Dr. Turner, Columbus, is Professor, Department of Pediatrics, The Ohio State University College of Medicine; and Assistant Chief of Staff, Children's Hospital.**

Experiences of this group may be divided into the following categories: (1) Family Visits; (2) Group Discussions; (3) Patient Contacts; (4) Field Trips; and (5) Student Produced Activities. The preceptor took the responsibility for planning each of the sessions with his students. He involved them in the planning by asking for their suggestions and used them insofar as they were relevant to the central concern of the course.

Family Visits

Each of the students was assigned to a family in the practice of the preceptor. The student made periodic visits to the family to observe interpersonal relationships, to understand the kind of people who make up the family, and to learn about their health problems or concerns. The family's cooperation was enlisted by the preceptor. They were prepared as to what to expect from the student visits and — perhaps more importantly — what *not* to expect. It was em-

From the Department of Pediatrics, The Ohio State University College of Medicine. Submitted June 4, 1968.
Reprint requests to Children's Hospital, Columbus, Ohio 43205.

phasized that the student was not a purveyor of medical information nor of medical care, but an observer who would visit them informally from time to time.

After the students visited their families, they reported to the group, and a general discussion of the different kinds of families and health problems took place. On his first visit, the student was not told what to look for, but was instructed to observe what he could about the family. Later, in one of the discussion sessions, students were given a guide for family visits. They were asked to consider, in making home visits, such questions as the following: How can the family be described socially? educationally? economically? How do the parents feel about each other? How does each parent feel about his role as parent? Is one member of the family clearly dominant? How does the family relate to the community? How does the family relate to institutions — such as school, church, the law, hospitals, practice of medicine? What are the primary concerns of the family? How do the members of the family relate to you as a visitor? Would you feel comfortable acting as the medical advisor for this family? and so forth. They were expected to try to secure the answers to these questions by indirection.

Following the second round of visits to the family, the students discussed the information obtained from their families. Some of the students felt uncomfortable at the time of their first visit and occasionally on all of the visits, but usually a friendship was formed and the students showed considerable ingenuity in dealing with whatever negative feelings were encountered.

Group Discussions

Group discussions, while perhaps the least exciting of the activities of the preceptor group, were useful. At the beginning of the year the students were asked, "What is it you would like to know about the physician-patient relationship?" We tried to establish some understanding of that relationship as well as the relationship between the medical student and medical educator. The students arrived at the insight that the physician-patient relationship resembles very much the teacher-student relationship. Medical ethics, economics, legalized abortion, laws relating to medical practice, etc., came up for discussion.

Patient Contacts

Students like to talk with patients. Within the first month each student had an opportunity to interview a patient without any guidance as to the structure of the interview. Later the students realized that they were not prepared for this activity and were given some ideas for securing information which will grow into what we call "taking the medical history." Before the second patient contact, the students were asked to answer this question: "What do I expect to learn from this experience?" Following the interview, they were asked to answer the questions "What actually happened?" and "What did I learn?" The students had an opportunity as a group to interview a patient who had had a renal transplant. The relationships of the patient and her family to physicians, hospital, and community were discussed. The students enjoyed the experience and appeared to be sobered by the thought that in a few years they would be in the role being played by the Chief Resident who demonstrated the patient. Another patient was seen when a third-year medical student presented a child whom he was studying in the Outpatient Department. The students heard the patient's cardiac murmur and saw the Outpatient Department in operation, this leading into the last nine weeks of the course devoted to a study of interviewing and physical examination.

Field Trips

Field trips were structured to provide insights into delivery of health services: what the community does to help people stay well or get well. A conducted tour of a hospital, arranged by a member of the group who had worked as an orderly, was carefully worked out and prepared with individuals who explained the activities of their departments. The students toured the Columbus State School (for mentally retarded persons). On another trip, it was the City Health Department; others, the Planned Parenthood Center, the Family and Children's Bureau, St. Ann's Hospital for Women, an elementary school, and a meeting of a local medical society.

At St. Ann's Hospital, the students interviewed a nurse who talked about breast feeding. A tour of the newborn nurseries and premature unit was conducted by the Head Nurse, who explained some of the problems of caring for prematures. They witnessed the delivery of a primiparous woman who had had a fertility problem, a miscarriage, who was Rh negative with rising antibody titer, and had had amniocentesis.

These field trips were arranged by the preceptor, who accompanied the students and participated in their question-and-answer sessions with the personnel of the agencies.

Student Productions

The effectiveness of students teaching themselves was demonstrated by a seminar on traffic accidents which was held in an auditorium with about 50 students and preceptors in attendance. The author selected the project and assigned students in his group the following roles: biostatistician, researcher, psychiatrist, toxicologist, surgeon, practicing community

physician. The students chose their own moderator and showed a film vividly demonstrating the trauma of traffic accidents. From that point on, there was no question about the matter under consideration. By their presentations the students demonstrated that they had taken the project seriously, had done some research according to the role assigned, and that they were able to present their material in a capable and interesting manner.

Discussion

The kind of teaching taking place in the preceptor groups in a patient-centered course for first-year medical students can be exciting and satisfying. The physician in practice in the community has a unique opportunity to make a contribution to medical education in such a course.

By visits to families in his practice, by group discussions which he moderates, by field trips and contacts with patients which he arranges, and by research which he promotes, the teacher-clinician acts as an arranger of situations in which learning about the practice of medicine takes place. If he has a genuine interest and commitment to teaching; if he treats medical students as physicians-in-training; if he encourages their participation in a variety of activities including experiences with patients; if he is open to questions and he plans and organizes sessions with some flexibility to meet the students' changing needs; and if he acts the role of the physician in full view of his preceptees, he will make a valuable contribution.

Members of the part-time faculty of the author's department (pediatrics) make up an integral part of the teaching staff at all levels of the pre- and post-M. D. curriculum. In the course that is the subject of this paper, first-year students were exposed to a consideration of the general approach to the patient. Other teaching activities of the community practicing physicians of the department are the subjects of later reports.

Summary

In 1966 and 1967 there were 30,828 part-time faculty members in 78 schools of medicine in the United States.[5] This report deals with the participation of physicians, who are practicing in the community, in a patient-related course in the first year of the medical curriculum. The activities of a group of six students whose preceptor is a practicing pediatrician are described.

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FUTURE OF GENERAL PRACTICE. — Fears that in the demand for greater efficiency in medical practice the more human needs of the patient may be forgotten are not groundless. One of the finest features of British general practice is the admirable relationships which have bound doctors and patients together. Some of the art in medicine, so essential when science was lacking, is outworn. But modern medicine takes patients as well as doctors anxiously into unfamiliar ground. If courtesy, kindness, and gentleness form part of the art of applied medicine then there will be more need than ever in the future for the exercise of these qualities in the doctor-patient relationship. It is never out of time for doctors to remind themselves that if one of their prime duties is to cure when possible so it is also to comfort always. — *British Medical Journal*, 3:383-384, Aug. 12, 1967.

Cryotherapy in Dermatology

W. DENNY ROBERTSON, M.D.

History of Cryosurgery in Dermatology

ONLY FOUR YEARS after the commercial production of liquid air and liquid nitrogen by Linde in 1895, Dr. A. Campbell White[1] reported on successfully eradicating verrucae, nervi, and small superficial hemangiomas using a liquid described as four parts oxygen to one of nitrogen by volume at a temperature of −321 F. He also applied the liquid air to leg ulcers, buboes, boils, and carbuncles claiming good response with only minimal sloughing. He used this form of cryotherapy for superficial malignant tumors and believed it was preferable to x-ray for the irradication of epitheliomas.

Liquid air was slow to be accepted as a therapeutic tool due to its scarcity and instability. Before the Dewar bulb was invented, a supply of five to ten gallons was needed for one day. Because of this, Pusey[2] in 1907 advocated the use of carbon dioxide snow as a substitute for the removal of various warts, vascular and hairy nevi, and plaques of chronic discoid lupus erythematosus. He did not advocate its use for any but the most superficial epitheliomas, realizing the shallow penetration achieved with this comparatively warm material of −78.5 C.

Freezing with carbon dioxide snow is relatively slow and fairly painful, probably due to the pressure required which causes freezing of adjacent normal tissue. With the increased availability of liquid nitrogen occurring as an inexpensive byproduct in the manufacture of liquid oxygen, CO_2 snow has not increased in popularity as a therapeutic tool. However, improvements in the technic of its use are still being sought. In 1965, Connor[3] advocated dipping pieces of solid carbon dioxide in acetone and applying the drops to the skin lesion so that rapid freezing could occur without pressure. In his article he mentions a rather unique method of obtaining these pieces of solid carbon dioxide by "dropping the delivery sack containing the daily supply of Dry Ice from the waist level to the floor."

As liquid gases became more readily available, Irvine and Turnacliff[4] in 1929 reported their results using liquid oxygen. They felt this was the superior form of treatment of warts, particularly of the "embedded palmar and plantar variety and of warts around and under the nails." Little pain was involved as long as the freezing stopped at the borders of the lesion and did not include the adjacent normal skin. They observed more rapid healing of poison ivy dermatitis, dermatitis herpetiformis, and herpes zoster with use of topical liquid oxygen and achieved satisfactory cosmetic results with seborrheic keratoses, one epithelioma of the rodent ulcer type, and one well-developed ulcerating epithelioma. No effect was noted on the plaques of psoriasis. In 1948, Kile and Welsh[5] reported on their successful use of liquid oxygen cryotherapy in over 1,000 cases, giving the technic of application and results of treatment of all types of warts, as well as condyloma acuminata, hemangiomas, leukoplakia, seborrheic and actinic keratoses, chronic discoid lupus erythematosus, folliculitis keloidalis, granuloma pyogenicum, and keloids.

In 1950, Dr. H. V. Allington[6] reported equally good results using liquid nitrogen. He was the first to describe a peeling treatment for postacne scarring performed by slowly rolling a large cotton applicator saturated with the liquid over the involved area. Dr. Fletcher Hall[7] also using liquid nitrogen, successfully treated x-ray keratoses, Bowen's disease, granuloma annulare, and one pseudomucinous cyst of the finger. He felt that the results obtained from longer periods of freezing without pressure were cosmetically superior to shorter periods of freezing with pressure. Grimmett[8] added lichen simplex chronicus, recalcitrant pustular eruptions of the palms and soles, creeping eruption (larva migrans), and Boeck's sarcoid to the list of lesions responding well to liquid nitrogen therapy. In 1967, Zacarian[9] reported good results in the treatment of molluscum contagiosum, keratoacanthomas, arsenical keratosis,

The Author

● Dr. Robertson, Akron, was a Senior Medical Student at The Ohio State University College of Medicine when article was submitted.

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dermatofibromas, chondrodermatitis nodularis chronica helicis, and cutaneous tags with liquid nitrogen.

Liquid Nitrogen — Technics of Application and Clinical Course

Local anesthesia may be used in extensive lesions or in people hypersensitive to pain such as children. However, this is usually not necessary, since the pain usually is not severe, is transient, and peaks about one to two minutes after the treatment is over during the thawing period. Lesions of the hands and feet, particularly around the nails and on the fingertips, generally are more painful than those elsewhere. A stinging pain is experienced when the lesion is first frozen white and hard. This becomes much less severe with continued freezing unless pressure is applied with consequent extension of the frozen zone. The pain returns for a minute or two as thawing takes place. The treated area may be somewhat uncomfortable for an hour or two afterwards.

If the greatest amount of freezing is achieved, a blister forms under and around the lesion in three to six hours; this may contain clear or sanguineous fluid, depending on the depth of necrosis. If it is in a location easily traumatized, it is best to puncture the blister under sterile conditions, repeating this procedure if it refills. After a couple of days, the vesicle surface flattens down and remains as a protective crust-like roof. This sloughs off in two to four weeks, when healing usually will have been complete.

Biologic Effects of Freezing

For over a half century, we have known about the necrotizing effect of extreme cold applied locally, but not until recently has any work been done on the exact temperature achieved in the tissues during freezing or the mechanism of cellular death. In his article on cryogenic surgery, Cooper[10] reviewed the literature on tissue freezing. Ordinarily, when tissue is cooled rapidly, the temperature will fall to as low as −15 or −20C before ice crystals begin to form. This is referred to as supercooling. After supercooling, there is a rise in temperature up to the freezing level of −2C. This is due to the energy released from the cell, which comes from the latent heat of crystallization; so the temperature will not fall again until all crystals have formed. The prior supercooling is due to the fact that there are very few crystalline nuclei in biologic tissue on which crystal formation can start. However, once formation of these nuclei and crystallization begin, a heat jump to the freezing level will occur as the heat is now being supplied by the crystallization process. The final temperature which will result depends on the original temperature of the freezing agent.

Five mechanisms are postulated to account for the cellular death due to extreme cold: (1) dehydration with resultant toxic concentration of electrolytes; (2) crystallization causing rupture of cellular membranes; (3) denaturation of lipid-protein molecules within the cell membrane; (4) thermal shock; and (5) stasis in the vessels supplying the area.

Depth of Cryonecrosis

If one considers the boiling point temperature of the various freezing agents (oxygen, −183 C; nitrogen, −195.8 C, carbon dioxide, −78.5 C [sublimates], and dichlorotetrafluroethane, −2 C), it is difficult to see why any agent would be superior to another since they all are equal to or lower than the freezing point of skin (approximately −2 C) and, with the exception of dichlorotetrafluroethane, lower than the critical temperature range (−18 to −20 C)[11] at which cryobiologists agree tissue destruction occurs. It is true that, for very superficial lesions such as early actinic keratoses, all but the last two mentioned agents work equally well. The main factor is the depth of freezing which must be achieved, since the skin is relatively resistant to freezing due to its abundant vascular supply and the fact that the frozen tissue itself acts as a good insulator. Kee[12] showed this well by demonstrating a seven- to eight-second delay in temperature change after applying liquid nitrogen to a 1 to 2 mm. thick piece of human callus overlying a thermocouple. Hydrating the callus decreased the delay to four seconds.

The abundant vascular supply of the skin is the main reason why, until recently, pressure always had to be applied to achieve any great depth of cryonecrosis. Normally, without pressure, freezing does not extend into the vascular dermis, so a clean line of slough occurs between an epidermal lesion and the underlying normal dermis which can then accommodate a regrowth of the adjacent normal epithelium. If, however, pressure is applied, the blood is squeezed from the capillaries and the epidermal-dermal line of demarcation is lost. This results in loss of normal dermis and consequent scarring. The main advantage of the colder agents is that they can freeze the entire lesion to the base of the epidermis without pressure. With such therapy, little, if any, scar results. Grimmett[8] has demonstrated this in his studies measuring the depth of necrosis from biopsies of skin previously frozen by various modalities and technics. He achieved a necrosing depth of only 1 mm. using a carbon dioxide stick and, even after 120 seconds of continuous spray with a mixture of 75 per cent dichlorotetrafluroethane and 25 per cent ethyl chloride, could not cause necrosis deeper than 0.5 mm. Using liquid nitrogen without pressure, he achieved a freezing depth of 1.5 mm. This did not change appreciably when the duration of treatment was increased from one to three minutes, suggesting a balance between the dermal vessels' ability to supply the heat and the capacity of the liquid nitrogen to absorb it. Interestingly, when a 1 cm. diameter pressure loop was used to occlude the blood from the area under treatment, the

necrosis was 0.5 to 1 mm. deeper with treatments up to 60 seconds; the lesions were frozen white immediately and it was often necessary to release the pressure before the lesion would begin to thaw. Furthermore, the pain induced seemed to be much less severe when the loop was used. Grimmett[8] has been able to achieve better results with treatment of deeper lesions such as plantar and palmar warts and "ice pick" acne scars by using hemostatic pressure during freezing. He states that little can be gained by extending duration of treatment beyond one minute and that adequate removal of superficial lesions such as actinic keratoses and leukoplakia is gained by applying the liquid nitrogen for only a very few seconds.

Cryosurgery of Cutaneous Malignant Lesions

Kee[12] found that superficial basal cell carcinomas responded well to topical liquid nitrogen using only "moderate pressure." Using this moderate pressure for 20 seconds on a "more nodular basal cell carcinoma," he found nests of viable malignant cells in the extreme depths of the lesion when it was excised 24 hours later.

Although the treatment of superficial benign and premalignant disorders of the skin does not require extremely low temperatures, quite low temperatures are mandatory for successful cryotherapy of skin carcinomas. This led Zacarian[11] to study the actual temperatures achieved with the application of liquid nitrogen to skin in different ways. He used thermocouples inserted 2 mm. deep between the skin and subcutaneous fat through an incision in the thigh. As mentioned earlier, the critical temperature range for cellular and tissue destruction is between −18 and −20 C. Zacarian found that, using a cotton swab, three applications were needed within the first 45 seconds to reach −17 C. A fourth application decreased the temperature to −26 C and at no time did the temperature fall lower than this at the 2 mm. skin depth. Using small copper disks previously cooled in liquid nitrogen, Zacarian[11] found that within the first 15 seconds the temperature fell to −30 C 2 mm. under the skin surface. Temperatures as low as −54 C were reached within 45 seconds. Larger disks caused an even more rapid drop in temperature to even lower levels.

Zacarian[9] later reported on his results in using these copper disks on the deeper skin malignancies. The disks varied in size from 0.5 to 3 cm. After freezing from 60 to 120 seconds, a hemorrhagic bulla with a serosanguineous exudate and crust developed within a few days. Healing was complete within four to six weeks with "minimal scarring." He also noted slight depigmentation at the treated sites which, in time, became less prominent. He did not encounter chondritis in treating malignancies of the nose and ear or tenosynovitis from treatment of the dorsum of the hands or fingers. For large and fungating neoplasms, the copper disks were inadequate. Recently he has used a device that will either apply liquid nitrogen via a felt tip or spray it directly on epitheliomas that are too large for the copper disks. His report was based on results in 240 patients with a total of 405 epitheliomas of which "11 were basosquamous cell carcinomas, 34 epidermoid carcinomas, 3 Kaposi's hemorrhagic sarcomas, 5 Bowen's disease, and 352 basal cell (rodent) carcinomas." In a one- to two-year followup of 151 patients, he has had six recurrences—a cure rate of 96.1 per cent. In spite of this, surgery remains the method of choice for removal of the deeper skin malignancies, with cryotherapy restricted for the more superficial lesion such as early basal cell carcinoma.

Complications of Dermatologic Cryosurgery

In general, cryosurgery has proved to be an excellent method for treating selected superficial skin lesions in comparison to other methods such as chemical or electrical destruction, or excision. It usually results in minimal scarring or may leave areas of hypopigmentation. The only individually reported complication, however, is a persistent neuropathy as a result of freezing certain superficially located nerves. Dr. Thomas E. Nix, Jr.[13] recently reported two cases of persistant numbness distal to the area of treatment; on the palmar aspect of the proximal phalanx of a finger and on the dorsal aspect of the hand. In both cases the liquid nitrogen was applied to an area overlying a superficially located nerve. Other areas which have important superficial nerves include the ulnar nerve as it crosses the medial epicondyle of the humerus, the "recurrent branch" of the median nerve in the palm (to thumb muscles), the common peroneal overlying the head of the fibula, the branches of the superficial and deep peroneal nerves on the dorsum of the foot, and the digital plantar proper nerves to the toes. To avoid this neuropathy Nix suggests that liquid nitrogen not be used in treating lesions located over the volar or lateral aspects of the proximal phalanges, and that when treating lesions on the dorsum of the hands, the skin be moved back and forth over the underlying fascia to dissipate the cold.

Summary

A large variety of superficial cutaneous lesions have been successfully treated with cryotherapy. The resulting cellular death due to freezing is a result of dehydration, crystallization, lipid-protein denaturation, thermal shock, and vascular stasis. In comparing the various methods used to achieve freezing, the main factor to study is the depth of cryonecrosis that can be achieved. Limiting factors include the thermal insulating properties of skin itself and its abundant vascular supply. Simplicity of technic, effectiveness,

and minimal residual scarring make cryosurgery an important technic in treating selected skin lesions.

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POSTOPERATIVE NARCOTICS. — This is the report of a group of private surgical patients indoctrinated preoperatively, who by and large had no need or a greatly diminished need for narcotics postoperatively.

The disadvantages of narcotics postoperatively are discussed. The time spent upon indoctrination of patients is thought to have been worthwhile since it resulted in at least an average and often better than average recovery, and a diminished need for catheterization, fluids intravenously, and other uncomfortable procedures.

The difficulty of a purely objective study of diminished needs for narcotics postoperatively is recognized. However, it seems there should be a reorientation of surgeons' attitudes in this regard to achieve a safer and smoother postoperative recovery. The patient will be much more comfortable and safe when his psychologic needs are taken into consideration.

A statistical study facilitated by the Research Committee of St. Luke's Hospital in Houston shows tremendous differences in narcotic needs as between the indoctrinated and the nonindoctrinated patient. — I. Alan Ulert, M. D., Houston, Tex.: *Southern Medical Journal,* 60:1292, December 1967.

Syphilis of Nose and Paranasal Sinus

HI YOUNG LEE, M. D.

IT IS IMPORTANT to remember that syphilis has been on the increase.[1] The reported cases of infectious syphilis in the United States reached a peak in 1947 and began a precipitous decline, which lasted for almost a decade. In 1957, 6,251 cases of primary and secondary syphilis were reported; but in 1963 there were 22,100, an increase of 255 per cent.[7] In 1962 there was an increase of more than 100 per cent in reported congenital syphilis compared to 1957, and the upward trend has continued. In 1964 a total of 4,140 cases of congenital syphilis were reported. Syphilis may affect almost any organ of the body and may imitate almost any other disease. We are presenting one case of syphilis which involved the nose and paranasal sinus.

Case History

A 79-year-old Negro male who had retired from maintenance work, was admitted on November 8, 1967, to the Ear, Nose, and Throat Section, of the Veterans Administration Hospital, Dayton, Ohio, for right exophthalmos of three months' duration. The patient had a long history of yellow nasal discharge and had not been able to smell for 25 years because of intermittent sinus trouble.

Recently he thought he had a recurrence of his sinus infection and was treated by a private physician. The gradual swelling of the right eye did not improve with the treatment of the sinus condition. The patient had no change in vision and denied weight loss and anorexia. He stated that the swelling was non-tender and appeared to be better or worse at different times of the day. There were no symptoms referable to the left eye. The patient smoked approximately one pack of cigarettes a day and did not drink. In 1962 he had incision and drainage of an infected hematoma and the removal of a foreign body from the left thigh. At that time the venereal disease research laboratory test was reactive, and he was treated with penicillin. There was no history of allergy.

On admission, physical examination showed a cooperative, 159-pound, elderly male. His blood pressure was 205/108. Visual acuity without correction was 20 /300, right eye and 20/100, left eye. There was marked proptosis of the right eye, which is forward and lateral. Exophthalmos meter reading was impossible because the proptosis was off the scale, therefore greater than the 15 mm. difference between the two eyes. There was no lag opthalmia; the lids closed and opened normally, but there was a limitation of adduction of the right eye with partial restriction of elevation and depression. A large, firm mass protruded from the superior nasal edge of the orbit, palpable through the right upper lid. This mass extended from the middle of the lid over the bridge of the nose and was non-tender. The right globe was uninvolved and normal except for the presence of a mature cortical cataract. The corneas and the chambers were clear (Fig. 1). The right pupil was sluggish but reactive. Fundoscopic examination was impossible because of the bilateral cataracts. On the right side of the nose, there was a large mass protruding into the right nasal passages from above. This mass had dilated vessels on the surface, and the middle turbinate was large with a large oro-antral fistula. It was evident that the entire nasal cavity had been involved in a destructive process. The turbinates were absent on both sides and there were no lateral walls to the nasal cavity. Both maxillary antra and the nose formed a large chamber. The posterior part of the septum, that is, the vomer area, was absent.

The nasopharynx was narrow and the eustachian orifices were not recognizable. There was a large oro-antral fistula on the right side. The oral cavity was edentulous with short soft palate. The indirect laryngoscopy examination was negative. The neck veins were not distended. There was a fourth heart sound and Grade II/VI ejection murmur at the sternal border. The patient had one plus pitting edema of both feet.

The Water's view of the skull, laminagrom of face, and stereoscopic Water's view demonstrated evidence of a low density mass in the region of the right antrum

The Author

● Dr. Lee, Dayton, is Resident in General Surgery, Veterans Administration Hospital, Dayton.

From the Surgical Service, Veterans Administration Hospital, Dayton, Ohio, and The Ohio State University College of Medicine, Columbus, Ohio. Submitted June 11, 1968.

extending toward the left and destruction of the medial superior orbital plate with extension into the right frontal sinus and somewhat past the midline into the left (Figs. 2A and 2B).

The chest x-ray showed moderate cardiac enlargement with left ventricular enlargement. The aorta was very tortuous and widened without calcification. Biopsy of the right nasal mass (large middle turbinate-like structure) showed acute inflammation, edema, and squamous metaplasia. Another nasal biopsy from the lateral and antral wall and right nasal mass showed acute exudative rhinitis and acute rhinitis. Spinal fluid contained 38 mg. per 100 ml. of protein and the venereal disease research laboratory test was negative. The serum VDRL was repeatedly positive (including 4 and 8 dilutions). The fluorescent treponemal antibody was also reactive. His hypertension workup, including the 24-hour urine, 17-ketosteroids determination, and intravenous pyelogram was negative and indicated essential hypertension rather than syphilitic aortitis. The serology findings, the biopsy results, the physical findings of huge perforation of the nasal septum, mucocele on the frontal sinus, and atrophic rhinitis led us to believe that a gumma was the cause of the disappearance of the lateral walls of the nose and the destruction of the vomer bone.

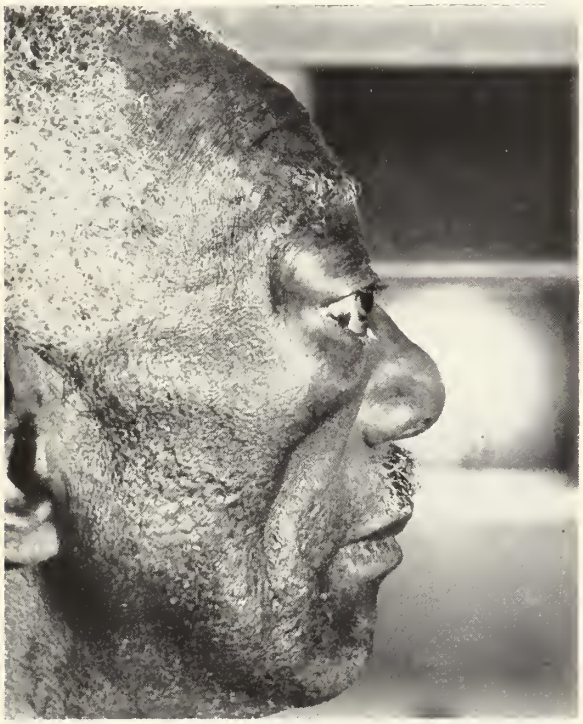


FIG. 1. *Preoperative view of face.*

On December 4, 1967, the patient was taken to the operating room and an incision running through both eyebrows was made. The center portion dipped down to the root of the nose. The frontal bone was exposed and the osteoplastic flaps were developed. The right frontal sinus was quite shallow and the left even more so. A large mucocele was seen extending from the lateral and inferior aspect of the right frontal sinus and was extended into the orbit (Fig. 3). There was a large portion of bony erosion. This mucocele was fluctuant at the time of admission but part of the mucocele had drained out



FIG. 2A. *A/P view of skull.*



FIG. 2B. *Lateral view of skull.*

1½ days prior to surgery through the site of a previous biopsy of the nose. At the time of surgery, only a large empty sac was present (Fig. 4). The size of the sac was 6 X 6 cm. Large pieces of gelfoam™ were used to obliterate the frontal sinus and the area of orbit. These were soaked in a solution of 1 Gm. of chloramphenicol. Figure 5 represents the picture two months after surgery.

Discussion

The type of lesion produced by syphilis on the mucous surfaces differs radically according to the duration of the disease and the degree of the patient's sensitization to the infecting organism. In early syphilis, cutaneous and mucosal lesions tend to be slight, insignificant, generally distributed, polymorphous, nondestructive of tissue, transient in duration (a few weeks or months), nonproductive of scarring, infectious because they are rich in treponemas, and almost always associated with positive serologic test for syphilis (STS).

As time passes, the untreated or inadequately treated patient becomes increasingly sensitized to the treponema, and recurring lesions tend to become more solitary and more destructive in character. Finally, when an allergy is fully established, the lesions tend to take on the typical characteristics of gumma.

The early mucosal lesions of syphilis fall into one or a combination of four morphologic groups (1) simple erosion; (2) papulo-erosion; (3) papulohypertrophy; (4) ulcerative lesion. Late syphilis in the nose and throat is extremely common and presents no particular diagnostic difficulty.[9] Due to the involvement of the nasal and palatine bones, sequestra frequently form, and the lesion may fail to heal until the dead bone has been surgically removed. The operation should be deferred until at least six months after the patient has had a minimum of 6,000,000 to 8,000,000 units of penicillin. In general, treatment should be renewed just before and resumed immediately after operation.[3]

Atrophic rhinitis is a chronic degenerative inflammatory disease of the nasal mucosa and underlying and neighboring tissues, anatomically characterized chiefly by progressive and pronounced atrophy of any



FIG. 3. *Tomography of right frontal sinus.*



FIG. 4. *Operative view of huge right frontal sinus.*

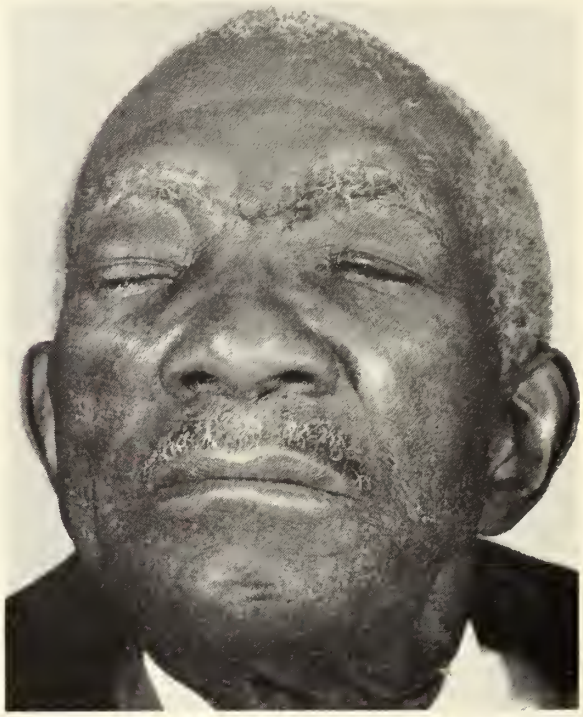


FIG. 5. *Postoperative view of face after 2 months.*

or all of the elements of nasal and paranasal structures. Syphilis is one of the causes of this disease. The fundamental pathologic change is the replacement of the nasal mucosa by a squamous, nonciliated epithelium as the biopsy of our patient demonstrated.[2] Syphilitic osteitis of the bony nasal septum has long been a hallmark of syphilis. The gummatous osteitis appears as a destructive or osteomyelitic lesion on the vomer associated with periosteal and osteal changes.[8] When there is a complete block of the nasofrontal duct or of the duct of the ethmoid sinus, no mucus can drain from the sinus into the nose. The mucocele above and medial to the eyeball is developed and caused by erosion of the floor of the frontal sinus or the lateral wall of the ethmoid labyrinth.[7]

Salinger[6] has employed the osteoplastic frontal sinus procedure with fat and stated that the operation is indicated when the frontal sinus is not too extensive, free from remote pockets and irregular projections, and when there are no complications such as osteitis. This technic seems the same as the osteoplastic method including thorough removal of all the mucosa, substituting the gelfoam for the fat or any other type of filling material.[4,5]

Summary

For the past few years, early syphilis has been increasing in incidence, and before long we can expect to see a rise in late syphilis. We have presented a case of syphilis involving the nose and paranasal sinus, and we have reviewed the pertinent literature.

Patients who have syphilis in the primary, secondary, latent (asymptomatic), or late (tertiary) stages, except neurosyphilis, receive a total of 6,000,000 units (10 injections) of either procaine penicillin G in aqueous suspension or procaine penicillin G in oil with 2 per cent aluminum monostearate (PAM). If the patient can return only once a week or is not likely to return, a dose of 2,400,000 units of benzathine penicillin G is given. Patients with neurosyphilis are given a total of 9,000,000 to 12,000,000 units (15 to 20 injections) of procaine penicillin G in aqueous suspension.

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FACIAL PAIN is a common symptom in the neurological clinic and presents interesting and difficult diagnostic problems. The remittent paroxysmal neuralgia is the best-defined of all the syndromes encountered in this connection. It is a disease of the elderly, shows considerable remissions, is unassociated with any abnormal physical signs, and always recurs. About three-quarters of all cases can be effectively relieved by Tegretol (carbamazepine), and in the remainder surgical section of the sensory root of the nerve remains the treatment of choice.

Post-herpetic neuralgia on the other hand shows little response to surgery but a marked tendency to spontaneous recovery, and is best treated by powerful analgesics, including heroin in severe cases. Migrainous neuralgia or "cluster headache" is a well-defined syndrome of unilateral first-division pain, remarkably responsive to ergotamine, but often unrecognized. Among structural causes of facial pain temporomandibular arthritis, nasopharyngeal cancer, and intracranial aneurysm should be remembered. It may also be a symptom of agitated depression and may respond to antidepressive drugs. There remains a considerable group of cases of distressing facial pain which lack the clear-cut characteristics of any of the forms described above, occur almost exclusively in middle-aged women, and resist every form of treatment but sometimes clear spontaneously. Henry Miller, M. D., Newcastle, England: *British Medical Journal*, 2:577-580, June 8, 1968.

Thrombotic Coagulation Time

Description of a Precise Method of Determination

DONALD E. YOCHEM, M.D.

IN 1958, Chandler[1] described an apparatus that will produce thrombotic coagulation when recalcified whole blood is placed in a circular loop of plastic tubing which is rotated. Other investigators[2-6] confirmed that the apparatus produces a thrombotic clot with morphologic features that resemble an in vivo thrombus. The method has been used to study, for example, the effect of cigarette smoking on thrombotic coagulation in vitro[2,5] and the antithrombotic effects of heparin and warfarin in patients treated with these drugs.[3]

The time interval between the beginning of rotation of a plastic loop containing recalcified whole blood and formation of a thrombotic clot (end-point) is termed the thrombotic coagulation time (TCT) or thrombus formation time (TFT).

Complete thrombotic coagulation and a definitive end-point do not occur consistently in the usual Chandler method. Therefore, the purpose of this study was to develop a method that would consistently produce both complete thrombotic coagulation and a definitive end-point, and give good reproducibility. The TCT is determined at 37 C (±0.5), which is desirable in this type of test, whereas determinations are made at room temperature with the usual Chandler method. Also, other refinements have been applied to this method in order to provide a precise test that might be useful for certain coagulation studies.

Materials and Method

Figure 1 shows a water bath that controls the temperature of the blood, and a modified Chandler apparatus with a positioned loop containing blood. The aluminum disc that holds the loop is about 7.5 cm. (3 inches) in diameter, is inclined 65 degrees from the horizontal, and is electrically rotated at 18 rpm. The apparatus is constructed so the part of the loop that contains blood is submersed in water during a test.

A temperature probe and telethermometer (YSI) showed that the temperature of the blood in the loop was 0.5 C lower than the water bath temperature at a room temperature of 24-26 C. Therefore, the water temperature was accurately maintained between 37.0 and 38.0 C.

Figure 2 shows a longitudinal section of a part of the circular loop joined with the usual external coupling A, and an internal coupling B, used with this method. Surgical grade Tygon™ plastic tubing (S-50-HL) was used for the coupling and loop. Dimensions in inches for the tubing are: Coupling length 0.4 (±0.010), inside diameter 0.093, outside diameter 0.171. Loop length 9.975 (±0.025), inside diameter 0.156, outside diameter 0.218.

Pyrex® bacteriological tubes (10 mm ID X 75 mm length), calibrated for 2.5 ml. to facilitate rapid and accurate measurement of the blood, were used. The tubes were silicone-coated with Siliclad® (Clay-Adams); and were thoroughly cleaned, rinsed in distilled water and dried after each use. Cork stoppers coated with Paraplast® (Scientific Products) were used to close the tubes.

Disposable plastic syringes, disposable 1.0 ml. plastic serological pipets (Falcon) and disposable needles were used, since there was no difference between the results obtained with these and siliconized materials. These results also were observed by other investigators.[2,5]

Unwashed tubing was used for all tests, since comparative tests did not show a difference in results between unwashed tubing and tubing washed with 0.9 per cent saline solution prior to use.

The following $CaCl_2$ concentrations were tested to determine the optimum concentration and volume to use for recalcification of 1.0 ml. of whole blood: 0.5 ml. of 0.02 M, 0.2 ml. and 0.3 ml. of 0.04 M, and 0.1 ml. of 0.25 M. Thrombotic coagulation occurred in every test regardless of the concentration and volume

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The Author

● Dr. Yochem, Columbus, is Medical Director, Research, Nationwide Life Insurance Company; and former Clinical Instructor of Medicine, The Ohio State University College of Medicine.

used. However, better reproducibility and shorter TCT's were obtained with 0.5 ml. of 0.02 M $CaCl_2$ and 0.3 ml. of 0.04 M $CaCl_2$ than with the other solutions. Since the TCT's were slightly shorter with the 0.02 M than with the 0.04 M solution, 0.5 ml. of the 0.02 M $CaCl_2$ was used for recalcification.

For rapid recalcification, a tuberculin syringe and 24 gauge x 3/8 inch needle were used to inject the $CaCl_2$ solution into the lumen of the loop containing blood by inserting the needle through the wall of the tubing (after preliminary rotation) while the loop remained in position on the disc. Thus, final rotation of the loop could be started the instant the needle was withdrawn.

Determinations were made promptly (approximately two minutes) after the blood was drawn; and in order to demonstrate reproducibility from a single sample, simultaneous determinations were made promptly by using two Chandler devices.

Connor[6] rotated the loop containing blood and fatty acids for 60 seconds prior to recalcification to allow incubation and mixing when testing the effect of certain fatty acids on thrombus formation in vitro. The loop also was rotated 60 seconds prior to recalcification for in vivo studies.[3] Therefore, the loop with blood was rotated 60 seconds before recalcification in the method described in order to keep this time factor constant, whether the method is used for in vitro or in vivo studies. Furthermore, rotation of the loop for 60 seconds in the water bath assures that temperature of the blood will always be 37C (±0.5) when it is recalcified.

The TCT was determined in blood from 100 presumably normal subjects, 45 males and 55 females, 18 to 74 years of age. Age distribution from youngest to oldest was relatively even throughout for both sexes. Samples were obtained when routine laboratory studies were made. Also, results with the Chandler method and this method were compared.

Simultaneous duplicate determinations were made on single blood samples from 20 subjects; and separate determinations were made one hour apart on samples from ten subjects. A different vein was used when separate samples were obtained from the same subject to avoid possible contamination of the sample with tissue thromboplastin.

Procedure for Test

The 0.02 M $CaCl_2$ was placed in a test tube which was kept in a water bath maintained at 37 C (±0.5); then 0.5 ml. of the solution was drawn into the syringe, with needle attached, and kept in the test tube ready for immediate use. The loops, test tubes for blood, and pipets are kept at room temperature, since comparative tests did not show a difference in results when these materials were kept at 37 C prior to use.

Each step of the procedure was performed promptly. Free flowing venous blood was obtained,



FIG. 1. *Modified Chandler apparatus and water bath adapted for temperature control of the blood (disc in raised position).*

needle detached, and the first 3 or 4 ml. removed. Then 2.25 ml. was transferred to the calibrated test tube containing 0.25 ml. of 3.8 per cent trisodium citrate. The tube was closed with a Parafilm™ coated cork stopper and inverted for mixing. The plastic tubing, with about one-half of of the coupling attached to one end, was held in a U-shaped position and 1.0 ml. of the mixed blood transferred (by gravity) to the tubing. Then the ends of the tubing were joined, and the loop placed on the disc and rotated in the water bath for 60 seconds. Following this rotation, the disc was stopped and the $CaCl_2$ solution injected into the lumen of the loop free of blood. The instant the needle was withdrawn, the disc was rotated and the stop watch started. The TCT was measured from

this instant to the end-point (thrombotic coagulation). The end-point occurs when the thrombotic clot makes the *first complete* revolution with the rotating loop. This occurs instantly and always gives a definitive end-point. Usually the thrombotic clot revolves continuously after the first complete revolution, but occasionally it makes two or three intermittent complete revolutions before revolving continuously. In these instances, the end-point also is interpreted when the thrombotic clot makes the first complete revolution.

Results

Prior to the end-point, the liquid blood column (due to gravity) remained in the bottom of the rotating loop and flowed by sliding along the wall of the tube as described by Chandler.[1] Thus, in effect, the blood flows opposite to the direction of the rotating loop.

At the end-point, a complete thrombotic clot occluded the lumen of the loop and instantly revolved with the loop in every determination when an *internal* coupling was used to join the ends of the loop. However, a complete thrombotic clot did not occur consistently when an *external* coupling of the Chandler type was used. When a thrombotic clot occurred with an external coupling, the clot did not always occlude the lumen of the loop and rotate with it. The liquid blood column only shifted a few degrees at the end-point as described by Hoak et al.[3] Thus, complete thrombotic coagulation and a definitive end-point that is easy to interpret occurred consistently when an internal coupling was used to join the ends of the loop. Furthermore, shorter TCT's and better reproducibility were obtained with an internal coupling.

Comparative studies showed that a temperature variation of only 2C decreased reproducibility; and that determinations made at 37 C (±0.5) gave better

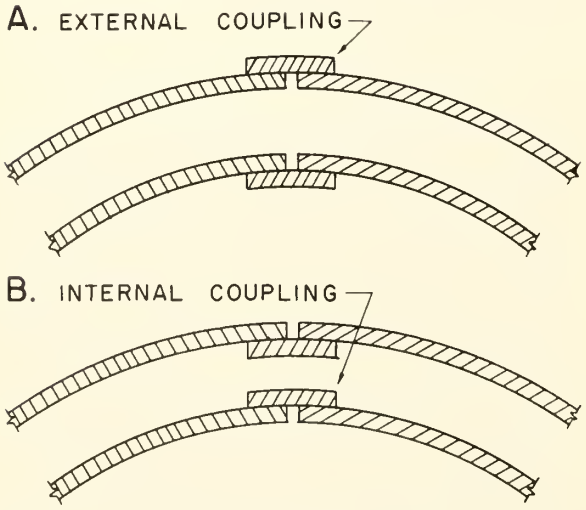


Fig. 2. *Longitudinal section of a part of the circular loop; (A) external coupling; (B) internal coupling.*



Fig. 3. *Gross thrombotic clot, 10 per cent formalin fixed, unstained (X 3). Portion of coagulated blood removed.*

reproducibility and shorter TCT's than when they are made at room temperature.

Figure 3 shows a thrombotic clot produced by this method. The white head is composed mostly of platelets and fibrin and is tough, whereas the larger portion of coagulated blood is composed mostly of erythrocytes and fibrin and is friable.

TCT in Normal Subjects

Figure 4 shows the TCT distribution of 100 normal subjects, 45 males and 55 females, 18 to 74 years of age. This empirical distribution closely approximates the theoretical normal probability distribution, considering the relatively small number of subjects tested.

There were no significant differences in the TCT between ages, or between males and females.

In Figure 4 time is in minutes and seconds. The relevant statistics are:

Range = 2:55 — 4:50
Mean = 3:44
Standard error of mean = 0:02.5
Standard deviation (SD) = 0:25

TCT Reproducibility

These results are shown in Figure 5. Graph A shows that the difference between duplicate TCT values of single blood samples from 20 subjects did not exceed 8.0 seconds in 15 subjects, and was no more than 13.0 seconds in five.

In another study, samples were taken one hour apart from each of 10 subjects. Graph B shows that the difference between the first TCT value and that obtained one hour later did not exceed 8.0 seconds in six subjects, was no more than 16.0 seconds in three, and in one subject the difference was 21 seconds. The TCT values for both reproducibility studies ranged from two minutes and 57 seconds to four minutes and 13 seconds.

Comments

Chandler[1] stated that incomplete occlusion of the lumen of the loop by a thrombus prevented consistent development of an end-point. In his method, an external coupling is used to join the loop. However,

when an internal coupling is used, complete thrombotic coagulation that occludes the lumen and a definitive end-point always occur. This coupling causes retardation of blood flow and thereby possibly enhances development of thrombotic coagulation. Perhaps the retarded flow and end of the coupling enhance platelet aggregation. Serial studies of thrombotic formation showed that platelets tend to aggregate at the coupling.

Engelberg[2] compared results obtained with the Chandler method and Lee-White clotting time and stated: "The observed disparity between thrombus formation times and clotting times after smoking also emphasizes that thrombosis and coagulation are different, albeit related, processes."

The TCT is determined at 37° C (±0.5) which conforms, for example, to the temperature standard used for determining the plasma recalcification clot time[7] and prothrombin time. By coincidence the 0.02 M $CaCl_2$, which is used in these latter tests, also gave the best results in the TCT test. In addition to rigid temperature control, other refinements have been applied to this method which gives good reproducibility with a standard deviation of only 25 seconds and a small standard error of the mean (2.5 seconds).

A study with this method is in progress to determine the effect of oral anticoagulant therapy on the in vitro TCT, and whether or not a relatively short TCT possibly predisposes a subject to thrombotic susceptibility.

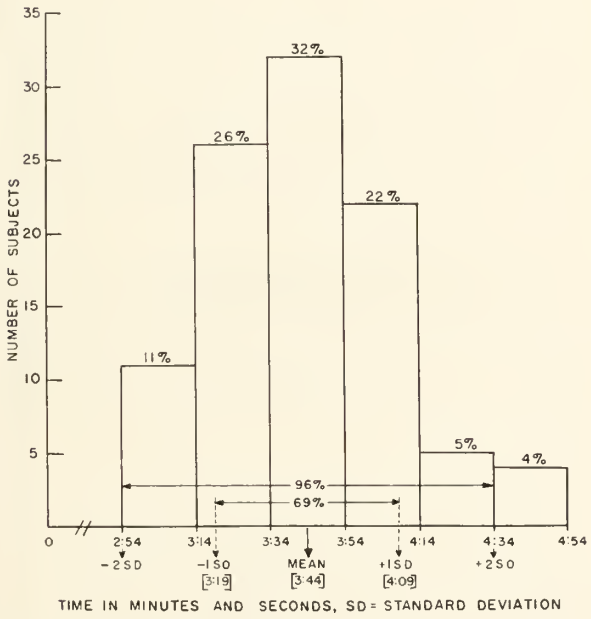


FIG. 4. *Distribution of thrombotic coagulation time (TCT) for 100 subjects. SD = 0:25.*

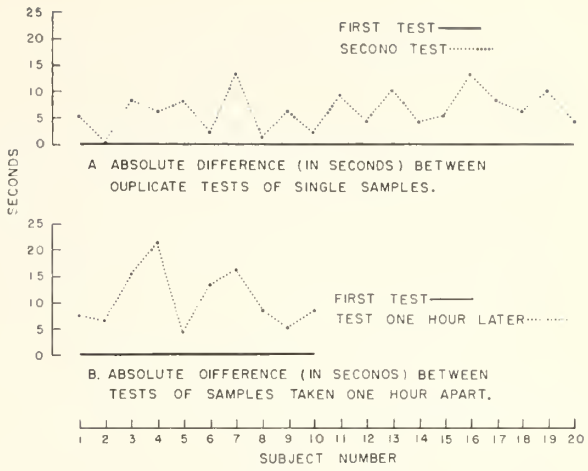


FIG. 5. *(A) Absolute difference (in seconds) between duplicate TCT values of single blood samples (20 subjects). (B) Absolute difference (in seconds) between TCT values of samples taken one hour apart from 10 subjects.*

Summary

A precise method of determining the thrombotic coagulation time (TCT) is described. The method produces a thrombotic clot with morphologic features that resemble an in vivo thrombus. Both complete thrombotic coagulation and a definitive end-point occur consistently, and the method gives good reproducibility.

Acknowledgment: The author wishes to thank Dr. Horace B. Davidson for laboratory facilities and the assistance of his technician O. J. Mottet, M. T. (ASCP), and Earl B. Schleicher for his assistance in constructing the modified Chandler apparatus.

Additional details for constructing the modified Chandler apparatus and reprint available on request. Address to author, 246 N. High Street, Columbus, Ohio 43216.

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The Disturbed Adolescent

Discussion of an Outpatient Psychotherapeutic Approach

NORMAN S. BRANDES, M.D.

THERE APPEAR TO BE three major categories of psychologic disorders of useful working importance when considering the emotionally disturbed adolescent:

(1) Disorders in the development of character and personality systems due to pathologic psychosexual growth.

(2) Adjustment reactions of normal adolescents, depressive, apathetic, or rebellious in nature and secondary to mishandling, painful pressures by school and family, and the internal physiologic-psychologic stresses of this period.

(3) Ego Impaired: Illnesses of the adolescent ego which cause the young person to react to the world around him with psychopathologic symptom formation.[1]

Regardless of the way the clinician classifies the emotional problems of the adolescent, whether they are of development, adjustment, or internalized etiology (often a combination of all three), common psychologic denominators in the understanding of this age group become apparent.

(1) **Parents represent "natural enemies" since they are real threats to the continuous striving of the adolescent to "be himself"** (Who am I? What am I? What will I become?). A psychotherapeutic approach to this age group is faced with the task of freeing the adolescent patient from this conflict, often riddled with guilt feelings and power struggles.

(2) **Adolescents, by their very nature, regardless of the presence or absence of emotional disorder, are under constant pressure from within and without to become a part of their peer group.** They are pressured to accept specific controls and modes of behavior and communication by their peers. Although they protest, "we have to be different," the demand for individualism submits to peer conformity.[2]

(3) **The need for some type of heterosexual adjustment is universal in adolescence.** It becomes a problem that can be over-reacted to, distorted, avoided, or integrated into patterns of interpersonal behavior. A psychotherapy plan is challenged by a young female who hides behind layers of obesity or anorexic thinness in order to prevent herself from interacting with members of the opposite sex. When she slims down or "fills out" and begins to feel important as a young female and human being, she becomes more free to engage in intimate interaction with males. Perhaps at no other time in history is today's adolescent more troubled with sexual identity problems as manifested by the tendency for girls to appear "boyish" and male adolescents to assume multiple feminine traits such as long hair, cologne, and worry over "figures."[4]

The less rebellion to the authority of the parents, the less association and greater behavior difference with the peer group, and the more difficulty with heterosexual adjustments, the more likely is the adolescent to be regarded "sick" by his peers. These are the adolescents that stand out as "oddballs" and "queers."[5]

Many adolescents who do not respond to an individual therapy relationship may develop therapeutic gains in a selected group therapy situation made up of adolescent peers. The influence of the peer group on adolescent behavior and feelings has a very strong impact because it represents a haven for support, justification, validation, and, above all, limits and restrictions. This peer influence is so complex that it defies control by the therapist in a one-to-one therapy relationship. In contrast, to place a disturbed adolescent in a therapy group organized and supervised by a psychiatrist is to harness a part of his world of peers. Incorporation of group technics into the

The Author

● **Dr. Brandes, Columbus, is a practicing psychiatrist; and Assistant Clinical Professor, Department of Psychiatry, The Ohio State University College of Medicine.**

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therapeutic program for the adolescent makes it possible that the direction of therapy achieves a more practical and realistic meaning. In individual psychotherapy, the therapist is often looked upon as one more authority figure in the adolescent's life.

Group therapy gives support and reassurance to fragile and incompletely developed ego strengths, thus helping to free the adolescent from the bonds of emotional disturbances, and to allow psychosexual growth to proceed. Also, it helps the adolescent to communicate thoughts and feelings more effectively and to relate to others with more freedom and security.

Within the group therapy experience, peers can set effective limits that the acting-out adolescent would not necessarily accept from adults. Therefore, some of the worthwhile goals in adolescent group therapy are the achievement of support and reassurance from peers, opportunity for further emotional growth, more effective communication, and exposure to acceptable limit-setting and validation of values.[3]

Individual psychotherapy sessions especially in the early phase of therapy help these young patients to develop insight more rapidly and serve to support continued group endeavors. The therapist can urge the adolescent in the individual session to bring up material in the group for validation by the other group members. A process of weaning away from individual therapy sessions can begin early with some teenagers and might have to continue on an occasional basis during the entire course of group therapy for others. The sooner the adolescent patient can "stand on his own two feet" in group therapy, the more rapidly healthier patterns of interaction seem to come about in other areas of his life. The following case examples illustrate the influence of the group on the adolescent patient.

Audrey was a high school senior at the time of her referral. Both parents described her as moody, unhappy, tense; she had crying spells that lasted for several hours which were accompanied by suicidal rumination. Although she had been a straight-A student, inability to concentrate and perform school assignments caused her grades to fall precariously. She bit her nails, had chronic difficulty focusing her eyes, and expressed deep resentment for her father whom she accused of being unjustly strict and coercive. Audrey was an attractive girl, who wore plain, unrevealing clothing and paid little attention to her grooming. She appeared to be painfully sensitive and had a great deal of difficulty in the verbal communication of her feelings. Tearfulness was frequent during the first few individual sessions. By the sixth individual therapy session, the idea of group therapy was introduced, and she was invited to "think about it." In the next four individual therapy appointments, her empty peer life and tendency to feel lonely and rejected were discussed. The possibility of group therapy was explored further, and her questions were answered regarding the adolescent group she would enter without revealing confidences about the patients in it, such as their identities. Audrey was started in group therapy along with a new male member to help them both feel less conspicuous. After several group experiences, she agreed that her individual therapy sessions could be suspended to an "on call" basis. Gradually, she became an active member of the group and began to concentrate on working through more comfortable ways of relating to the other group members.

Signs of her depression disappeared although her difficulties in the area of school work continued. After her graduation, she announced that she had taken a summer job at camp but would drive five hours round trip, once a week, to attend the group session.

John was 19 years of age and worked for his father in a small farm implement business. "I used to suck my right index finger when I was a little kid. Now I'm doing it again, in private. I seem to be sensitive about things. If someone has an idea, I just can't go along with it. I have to argue. I can't seem to agree with anybody. I have dreams of rapes and things like women being tortured. This gives me pleasure. I couldn't stand this happening to anyone in real life." This young patient was afraid of his aggressive dreams and thoughts. He confined his heterosexual relationships to prostitutes. One year of individual therapy sessions seemed to encourage further isolation from others and a resentful dependence on the therapist. He was introduced to group therapy after careful preparation and instruction. It was agreed that his individual sessions would be continued on a once-a-month basis. After seven months of exposure to a dynamic group of older adolescents, he began to reach out to other young people outside the group and his dreams of violence decreased in frequency.

Jane was 17½ years of age and was away from home for the first time at a local college. The second week of her freshman year, she told her parents she "was unhappy, ugly, inadequate, no good, and was too frightened to remain a student." She wanted to return home. Poorly prepared to go off to college, Jane had been living a life designed to please everyone, especially her overprotective and controlling parents. She tearfully confessed that she was "putty in anyone's hands" and yielded to all sorts of pressures to please people. Jane was scheduled three times a week for individual sessions and given tranquilizers to help her over her "school phobia" crisis. When her agitation and depressive symptoms diminished to a safe level, she eagerly began group therapy. The group helped Jane to understand some of the dynamics involved in her slave-master relationship with her parents and supported her in dating a boy of another religion, frowned upon by her domineering parents. After six months of group therapy she felt safe enough to disagree with the group therapist and on

one occasion argued with him about a charge for a missed group session.

Not all adolescents are suitable for group therapy, and some young patients need long periods of individual therapy prior to, or as a supplement to the group experience and vice versa. Sometimes, group therapy can prepare the adolescent for a more intensive, individual treatment approach later on. Occasionally, with the adolescent patient's permission and the knowledge of the group members, meetings with the parents or siblings are necessary. Often, adolescent patients will forbid the therapist to meet with the parents and this wish must be honored. Like other forms of psychotherapy, group psychotherapy is not a panacea. It is a valuable treatment medium that lends itself most naturally to the psychologic phenomena of adolescence. Although group therapists may approach group therapy technics with varied training backgrounds, the group process becomes the strong reality factor that brings about universal group reaction and interaction.

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CHRONIC CHOLANGITIDES. — A number of different chronic diseases affect the intrahepatic bile radicles or cholangioles. They include primary and secondary sclerosing cholangitis, primary biliary cirrhosis, chronic cholestatic drug jaundice, atresia, and carcinoma. Aetiological factors include infection, immunological changes, hormones, and congenital defects.

Patients with chronic cholestasis have decreased bile salts in the intestinal contents and suffer from a bile salt deficiency syndrome. Failure to absorb dietary fat is managed by a low-fat diet and by medium-chain triglycerides which are absorbed in the absence of intestinal bile salts. Fat-soluble vitamin deficiencies are prevented by *parenteral* vitamins A, D, and K_1. Calcium absorption is defective, and improvement may follow intra-muscular vitamin D, medium-chain triglycerides, a low-fat diet, and oral calcium supplements.

In partial intestinal bile salt deficiency the anionic bile-salt-chelating resin cholestyramine controls pruritus though steatorrhoea increases. Pruritus associated with total lack of intestinal bile salts is managed by methyl-testosterone or norethandrolone, though the jaundice increases. — Sheila Sherlock, M. D., London, England: *British Medical Journal,* 3:515-521, August 31, 1968.

Clinical Note

Relief of Acute Occupational Tenosynovitis

EARL J. LEVINE, M.D.

SOME WORKERS from the eviscerating department of a local turkey processing plant developed painful inflammation of the hand. In eviscerating turkeys, the workers must insert a hand into the carcass of the bird through the vent and draw out the entrails. The job is rapid and repetitive; the dead birds are moved through the operation on an "assembly line" at a rate of about 1,800 turkeys per hour. Manual evisceration was obviously responsible for the disabling tenosynovitis suffered by some of the workers, especially during the "break-in" period.

The effected hands were swollen, stiff, and painful at the metacarpophalangeal joints. Pain increased at night, often interfering with sleep. I prescribed aspirin, application of heat, and rest. The treatment relieved symptoms, but the time off the job disrupted plant operations. Conjunctive steroid and salicylate tablets four times a day were prescribed, and inflammation subsided, but again only after several days' rest. Then I decided to use 25 milligrams of indomethacin, four times a day. This drug was selected because its previous use in acute bursitis had produced impressive results.[1]

Nineteen patients with tenosynovitis of the hand received indomethacin, and 17 had good to excellent results. Symptoms subsided promptly, although several patients required an analgesic as an adjunct for night-time relief of pain. Of the two who failed to benefit from the drug, one stopped because of an apparent sedative effect, and the other did not improve after six days of therapy.

It appeared that the sooner treatment began, the shorter the disability; 2 to 3 capsules a day for a day or two was adequate for relief. Such short-term treatment would also seem to minimize the chance of adverse reactions. Although the experience with the drug in tenosynovitis has been brief, it suggests that its anti-inflammatory effects are beyond question and quick in onset.

The Author

● Dr. Levine, Wellston, is Plant Physician, Ralston-Purina Turkey Processing Plant.

Submitted April 23, 1968.

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LEAD POISONING. — Many partially sighted children use the mouth, lips, and tongue as an aid in identifying objects — this has been termed discriminatory pica. Investigation of a case of lead poisoning in a pupil at a residential school for the blind led to the discovery of others with asymptomatic lead poisoning, all of whom had the same habit.

All the children recovered without treatment when they abandoned their habit of discrimination by use of the mouth. Authorities responsible for schools for the blind should be aware of this risk. — A. C. Ames, M. B., London, England, and P. N. Swift, M. R. C. P., Kent, England: *British Medical Journal,* 3:152-153, July 20, 1968.

Anomalous Muscle Bundle of the Right Ventricle

A Case Report

ALAN B. MILLER, M.D., and JOSEF EDELSTEIN, M.D.

IN SEPTEMBER 1961, Lucas, Jr. et al[1] and Tsifutis et al[2] reported 13 cases, in two separate series, of anomalous muscle bundles within the right ventricle. This produced a two-chambered ventricle with a proximal high pressure chamber between the tricuspid valve and the anomalous muscle bundle, and a distal low pressure chamber between the anomalous bundle and the pulmonic valve. Both series were later published[3,4] in great detail emphasizing the frequent association with ventricular septal defect and less common with valvular pulmonic stenosis. Of great importance was the fact that these cases had to be differentiated from isolated ventricular septal defect and from acyanotic tetralogy of Fallot, and also, that at the time of surgery for correction of ventricular septal defects, it was important to keep this entity in mind since the opening between the muscle bundle fibers could be interpreted as the ventricular septal defect and erroneously closed with all its negative consequences. Since these two series were published, a number of reports have appeared in the literature[5-11] amounting to 23 other cases. Hindle, et al[13] recently reported six new cases recognized at autopsy.

This report will present a case of anomalous muscle bundle of the right ventricle with no other associated defect in an asymptomatic 17 year old patient with a marked pressure gradient at rest across the anomalous bundle.

Case Report

A 17 year old Negro male was admitted to Mt. Sinai Hospital on December 30, 1966 with chest pain and fever of one week's duration. The pain was not severe and was not associated with exertion. The patient denied any symptoms of cardiac failure and had no cough, hemoptysis, syncope, or cyanosis. He has had no difficulty in participating in athletic activities. The patient was the product of a full-term pregnancy, an uncomplicated labor and delivery. The only pertinent previous medical history is that of treatment for allergic dermatitis and asthma in 1965 in another hospital. At that time no cardiac murmurs or other cardiac abnormalities were described in the report available to us.

Physical examination on admission revealed a blood pressure of 150/70 in both arms. Heart rate was 100 beats per minute and regular. Respirations were 18 per minute and oral temperature was 99.4 F. Generally the patient appeared to be a well-developed, negro male in no acute distress. Examination of the eyes, ears, nose, and throat was unremarkable. Funduscopic examination was normal. The neck was supple and no bruits were heard. There was no venous distention. No masses were palpable in the neck. The lungs were clear to percussion and auscultation.

Examination of the heart revealed a regular rhythm and no cardiac enlargement. A prominent systolic thrill was present along the lower left sternal border. A Grade IV/VI harsh systolic ejection murmur was heard in the same area radiating to the third left intercostal space. The murmur decreased with inspiration. The second heart sound was normally split with a diminished intensity of the pulmonic component. No diastolic murmur or gallop rhythm was heard.

No masses were palpable in the abdomen, and there were no peripheral edema, clubbing, or cyanosis. Peripheral pulses were equal and intact. There was

The Authors

- **Dr. Miller, Cleveland, is Resident in Medicine, The Mt. Sinai Hospital of Cleveland.**
- **Dr. Edelstein, Cleveland, is Clinical Instructor in Medicine, Case Western Reserve University; and Chief, Department of Cardiology, The Mt. Sinai Hospital of Cleveland.**

Submitted June 6, 1968.

Reprint requests to Josef Edelstein, M. D., 1800 East 105th Street, Cleveland, Ohio 44106.

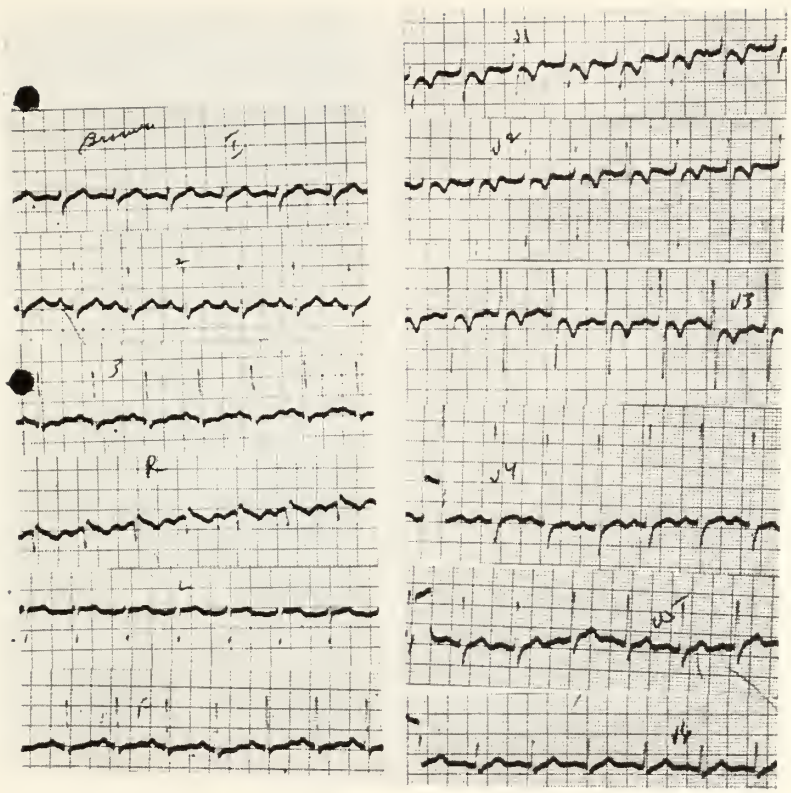


FIG. 1. *The electrocardiogram revealed a sinus tachycardia at a rate of 115 per minute with a QRS axis of plus 100° in the frontal plane. A "juvenile" pattern is noted in the precordial leads.*

no lymphadenopathy present. Neurologic examination was normal.

An electrocardiogram revealed sinus tachycardia at 115 per minute with a QRS of plus 100° in the frontal plane. Inverted T waves representing a juvenile pattern were noted in leads V^1 through V^4 (Fig. 1). A vectorcardiogram showed terminal forces superior and to the right in the frontal and horizontal planes and an increase in anterior forces in the horizontal plane, interpreted as evidence for early right ventricular hypertrophy (Fig. 2). Chest x-ray (Fig. 3) and fluoroscopy were both within normal limits. No chamber enlargement was noted. Laboratory studies including hematologic evaluation, *lupus erythematosus* preparations, antinuclear factor, rheumatoid factor, serology, heterophil agglutination test, electrolyte, and protein determinations were within normal limits. All blood cultures and urine cultures were negative.

Throughout his hospital stay, the patient maintained a low grade fever of 99 F. A cardiac catheterization was performed on the 14th hospital day. Blood samples were taken for determination of oxygen saturation and pressures were recorded from the various chambers (Table 1). No gradient was present across the pulmonic valve, however, a gradient of 60 to 75 mm. of Hg was present at rest between the outflow and inflow tract of the right ventricle (Fig. 4). Cineangiograms were done from the main pulmonary artery with the patient in a 60 degree left anterior oblique projection. The pulmonic valve, the main pulmonary artery, and its two main branches appeared normal. During recirculation to the left heart, intact atrial and ventricular septa were demonstrated. A right ventricular angiogram done with the patient in an anterior posterior, and in a 30 degree right anterior oblique projection showed a filling defect in its midportion representing the anomalous

TABLE 1. *Data from Cardiac Catheterization*

Chamber	O2 Saturation	Pressure (mm. Hg)
SVC	75	
RA	82	0-10 (5) *
RV inflow	80	85-100/7
RV outflow	83	25/5
PA	75	25/10 (15)*

SVC = Superior Vena Cava
RA = Right Atrium
RV outflow = Outflow Tract Right Ventricle
RV inflow = Inflow Tract Right Ventricle
PA = Pulmonary Artery
* mean pressure in parenthesis

muscle bundle (Fig. 5). The inflow and outflow tract communicated via at least three narrow channels seen within the anomalous muscle.

A definitive surgical procedure seemed advisable but was refused at this time by the family.

Discussion

As mentioned by Lucas et al,[3] in infundibular obstruction of the right ventricle, the hypertrophied muscle does not cross the right ventricular cavity from one wall to another, and thus it differs from the cases with anomalous muscle bundle. The latter entity is produced by a congenital, anomalous muscle within the cavity of the right ventricle and not by hypertrophy of any of the usual components of this chamber. Cardiac catheterization and angiography are the only accurate means of diagnosis during life. According to Hartmann et al,[4] the auscultatory findings are very similar in most of these patients, characterized by a loud, harsh, systolic murmur at the left sternal border with a systolic thrill and a decreased pulmonic component of the second heart sound. Electrocardiogram and chest x-ray are frequently nonspecific and the degree of right ventricular hypertrophy present will depend on the magnitude and duration of the obstruction and the presence of any associated defects.

A second publication by Hartmann[7] points out that the muscle bundles can be present since infancy but the degree of obstruction increases with age as the muscle progressively becomes more hypertrophied.

Warden, Lucas, and Varco[9] reported some cases in which isoproterenol infusion produced a great increase in right ventricular inflow pressure, as seen in idiopathic hypertrophic subaortic stenosis. Their series showed six patients with associated pulmonic stenosis and five without other abnormalities.



FIG. 3. *Chest x-ray in an AP view showing a normal heart and pulmonary vessels.*

The presence of a normal pulmonary second sound in association with other findings of pulmonic stenosis should suggest intracardiac obstruction of flow through the right ventricle. Also, the murmur in this entity is located lower than that heard in valvular pulmonic stenosis.

Surgical therapy is the only available means of cure of this defect and should be performed on patients having gradients greater than 50 mm. of Hg across the obstructed area at rest, or clinical symptoms, i.e. syncope, angina, etc. during exercise, interpreted as secondary to the obstruction in the right ventricle. The surgical excision of the anomalous

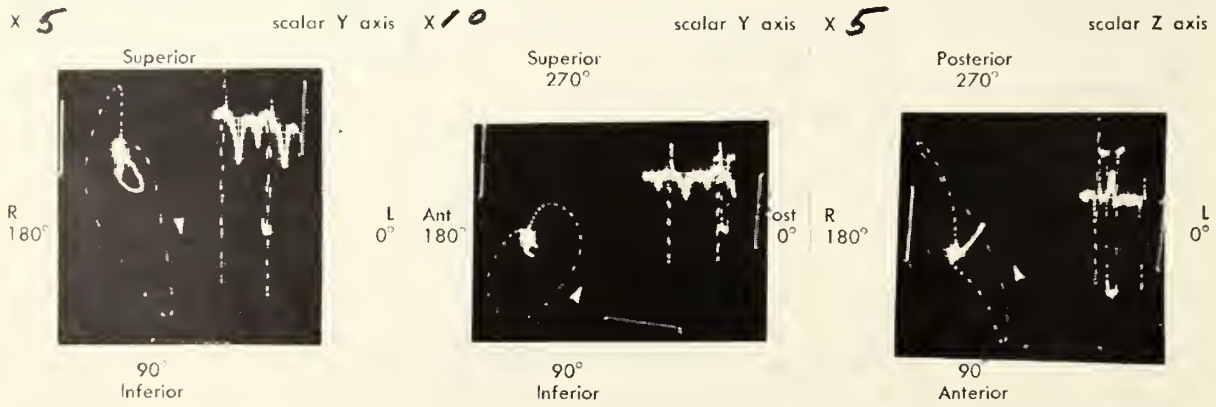


FIG. 2. *A vectorcardiogram (Frank system) revealed evidence of early right ventricular hypertrophy as evidenced by terminal forces to the right and superiorly in the frontal plane and an increase in anterior forces in the horizontal plane.*

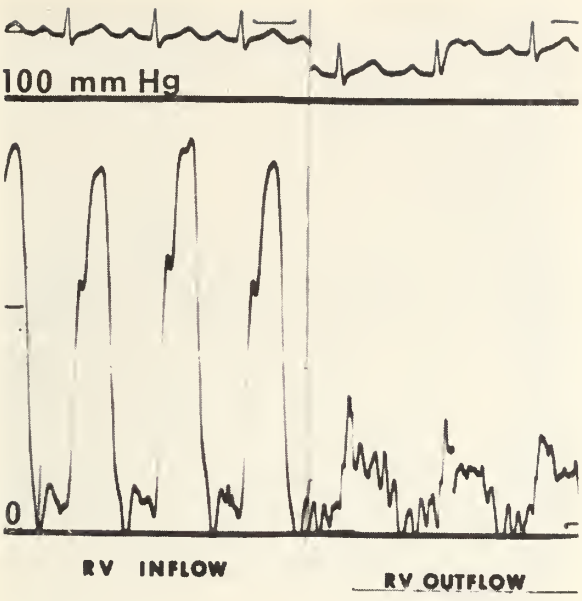


FIG. 4. *Right ventricular systolic pressures in the inflow tract are around 85 to 90 mm. Hg at rest, while the outflow tract chamber shows systolic pressure of 25 mm. Hg.*

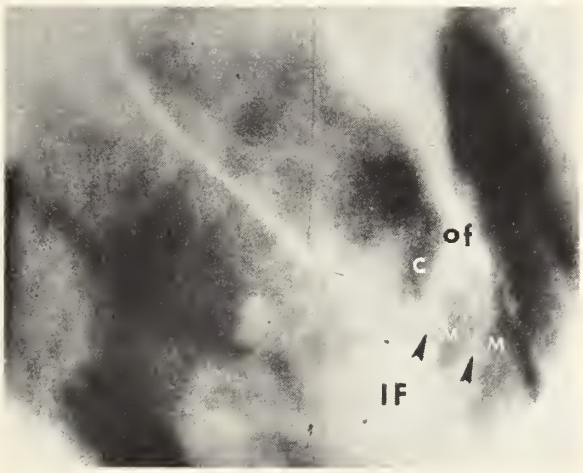


FIG. 5. *Right ventricular angiogram in a 30° RAO projection reveals two radiolucent defects representing the muscle bundle (M) dividing the right ventricular cavity into inflow (If) and outflow (Of) chambers which communicate via two narrow channels (arrows). C=Crista Supraventricularis.*

bundle is supposedly a simple procedure for a skillful cardiovascular surgeon. Some patients though, have developed mild right ventricular failure following surgery for a transient period of time, but all responded to usual therapy. It is not clear why failure develops and some thoughts have been expressed as to changes in shape of the ventricle or decreased contractile force following the resection of the anomalous bundle.[12]

Summary

A case of anomalous muscle bundle within the right ventricle is presented in detail.

This patient had no other associated defects. A high pressure chamber is created between the tricuspid valve and the anomalous muscle bundle and communicates through small openings in the muscle bundle with a low pressure chamber between the anomalous muscle bundle and the pulmonic valve. Cardiac catheterization and angiography are the only available means for a positive diagnosis. Surgical excision of the anomalous muscle is the only successful form of therapy.

Cases previously reported in the literature are reviewed.

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Reprints of Fat-Controlled Diets Available from Heart Society

In answer to many requests the Ohio State Heart Association has prepared bound copies of the series, "A Baedeker for Fat-Controlled Diets," which appeared in *The Ohio State Medical Journal.* Reprints in limited supply are available, without charge, from the Ohio State Heart Association, 10 East Town Street, Columbus, Ohio 43215. The series which appeared on the "Heart Page," a regular feature of *The Journal,* is a project of the Professional Education Committee of the Ohio State Heart Association.

Sacrococcygeal Teratoma

A Case Report

THOMAS L. MANNING, M.D., ABDUL F. NAJI, M.D.,
and C. CRUZ, M.D.

SACROCOCCYGEAL TERATOMAS are of significance to the obstetrician. These tumors not only may interfere with the delivery of the infant,[1] but they may lead to errors in the clinical impression. Rupture of the teratoma or excessive bleeding from the tumor during labor may lead to the death of the newborn. Many of these tumors are benign, and following successful resection, the infant may develop and function normally. In the case presented here, incorrect diagnoses of vertex presentation and placenta previa were made. After delivery the tumor was mistaken by the physician for meningomyelocele.

The Authors

- Dr. Manning, Cleveland, is Attending Physician, Department of Obstetrics and Gynecology, St. Alexis and St. Ann Hospitals.
- Dr. Naji, Cleveland, is Director, Department of Pathology, St. Alexis and St. Ann Hospitals; Visiting Pathologist, Cleveland Metropolitan General Hospital.
- Dr. Cruz, Cleveland, is Resident in Pathology, St. Alexis Hospital.

Case Report

The mother was a well-developed, well-nourished, 19 year old white woman, gravida 1, para 0. She was admitted to the hospital on August 5, 1967 at 31 weeks gestation. The membranes had ruptured the previous day with a moderate amount of vaginal bleeding. At the time of admission she had uniform uterine contractions every five minutes. The fetal heartbeat was heard over the right lower quadrant with a rate of 130 beats per minute. The clinical impression was intra-uterine pregnancy with vertex presentation. The possibilty of placenta previa was considered due to the presence of a soft mass occupying the cervical os. Caesarian section was not done because of questionable fetal heart sounds. The patient delivered a stillborn female infant through a midline episiotomy ten hours after the rupture of the membranes. It was a frank breech presentation.

The infant weighed 2,200 Gm. and measured 36 cm. (crown-heel). There were no significant anatomical abnormalities other than a sacrococcygeal teratoma. No evidence of metastatic tumor was present.

The sacrococcygeal tumor was oval, measured 19.0 x 11.5 cm., and was attached to the buttocks and pelvis. It was covered by thin, stretched, tan colored skin on which were wide foci of excoriation and erosion, especially on the distal surface. The tumor displaced the external genitalia and the anorectum distally and anteriorly (Fig. 1). Compression of the rectum did not cause obstruction. This was demonstrated by free flow of barium into the rectum and sigmoid colon (Fig. 2). The tumor lobules were separated by thin membranous septa. Each large lobule consisted of smaller, ill-defined secondary lobules of moderately soft, pale reddish-gray tissue (Fig. 3). Numerous cysts of varying size within the tumor contained clear mucoid material. The proximal portion of the tumor extended into the pelvis anterior to the sacrococcyx, reaching as high as the level of the second sacral vertebra. The pelvic bones, spinal cord, and meninges were intact. In its posterolateral aspect the tumor compressed the gluteal muscles. The most distal portion of the tumor revealed foci of interstitial hemorrhage. Multiple sections did not disclose grossly recognizable organs.

Microscopically the tumor was not encapsulated. It extended directly into the perirectal and perineal soft tissue. There was well differentiated, partially differentiated, and undifferentiated tissue. A striking feature was the disorganization and irregular distribution of the different types of tissue. Cartilage was visible in the vicinity of glands and primitive neuroepithelium. Tubules lined by tall mucin-secreting epithelium with smooth muscular walls were suggestive of large intestine. The epithelium was a single layer of cells without spherical or tubular glands. Columns of polyhedral cells surrounding

Submitted June 26, 1968.



FIG. 1. *Sacrococcygeal teratoma, anterior view.*



FIG. 2. *X-ray of infant with teratoma (barium enema).*

ducts were suggestive of liver tissue. Lobules of pancreatic acini with ducts were present, but no islets of Langerhans cells were seen (Fig. 4). Cartilage tissue simulated phalanges, a vertebra, a mandible and a sacrum (Fig. 5). A slight degree of ossification in some cartilage fragments was noted.

The partially and well-differentiated epithelial and mesenchymal tissue was separated by uniformly dispersed stroma. The stromal cells had oval nuclei, nearly devoid of cytoplasm. There was a tendency to stromal differentiation into fibroblastic and fibrocytic tissue. The stroma contained recognizable glial tissue. Ocular tissue simulating retina and choroid was present in several sections (Fig. 6).

Discussion

With few exceptions, sacrococcygeal teratomas are discovered at birth. In 111 cases reviewed, Waldhausen[2] found that the predominent incidence of the tumor was in female patients. He also observed that the incidence of malignancy is greater in children than in the newborn. Riker[3] mentioned that one congenital sacrococcygeal tumor is found in 34,582 births. Teratomas represent only a small percentage of these tumors. Frequently an incorrect diagnosis of meningomyelocele is made.[4]

Sacrococcygeal teratomas contain a variety of tissue types. When the tissue is predominently a mature type, the tumor may resemble a dermoid cyst. Occasionally well-differentiated organs such as intestine or pancreas may be recognized. In one case an embryonic scapula was seen.[5] In another, rudimentary arm bones and a hand were reported.[6] Nicholson[7] described carefully studied specimens of digit-bearing teratomas. He stated that the digital nerves of the teratoma came from the sacral nerves of the patient. "The organism treats the tumor as flesh of its flesh by supplying it with sensory nerves, and the skin of the tumor reacts as a physiological part by supplying the appropriate receptors." Precocious sexual and somatic development has been reported in a male infant with a presacral teratoma containing androgen-producing tissue.[8]

Malignant changes are frequently observed in these teratomas.[9] The epithelial and/or stromal tissue may predominate the malignant portion.

Occasionally it is difficult to determine the benign or malignant nature of these tumors, and a diagnosis of malignancy may only be made following tumor recurrence after surgical resection. In the case reported, the size of the tumor, its rate of growth, abundance of embryonic tissue, and direct infiltration of striated muscle and soft tissue of the buttock suggest malignancy. However, this diagnosis must be made with reservation. Wells[10] commented on a case of a sacrococcygeal teratoma in a four months fetus containing abundant immature neuroblastomatous tissue.

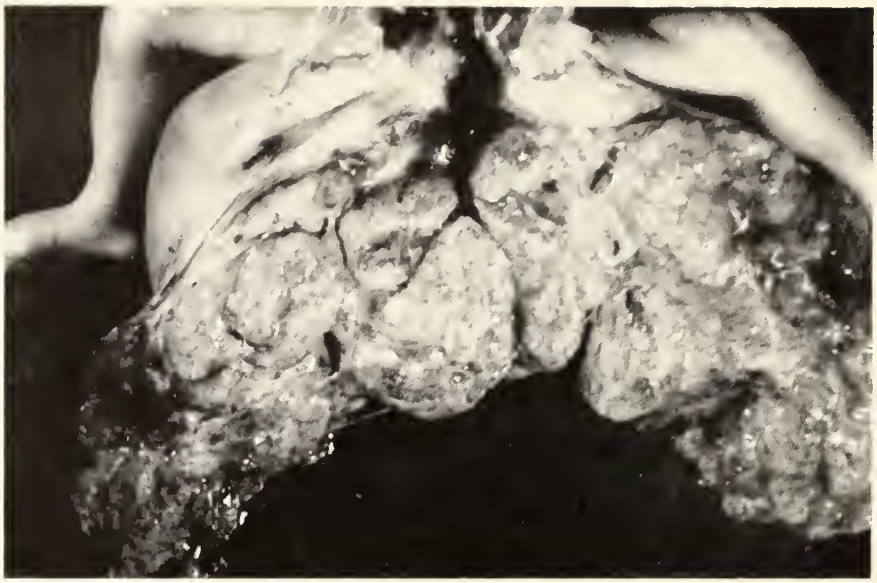


FIG. 3. *Cut surface of sacrococcygeal teratoma.*

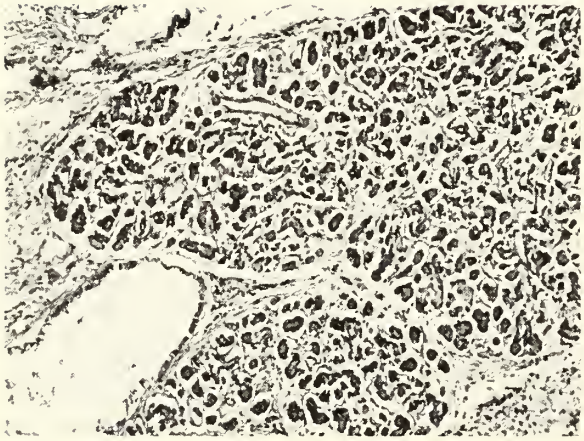


FIG. 4. *Photomicrograph. Sacrococcygeal teratoma. Glandular and ductal tissue resembling pancreas. H & E.*

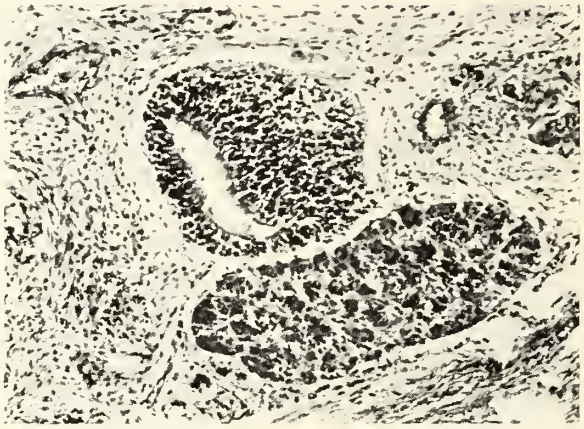


FIG. 6. *Photomicrograph. Sacrococcygeal teratoma. Neuroepithelium (top). Glandular tissue resembling liver (bottom). H & E.*



FIG. 5. *Photomicrograph. Sacrococcygeal teratoma. Cartilage tissue resembling a vertebra. H & E.*

"Is it not possible, or even probable, that had the fetus gone on to term, the undifferentiated nerve elements would have gone on to greater differentiation and the teratoma then been classed as benign teratoma with preponderance of nerve tissue?" This observation is a reminder that every benign teratoma must have been an embryonic growth to begin with.

Willis[11] believes that if the tissues of a teratoma mature at the same rate as the tissues of the bearer, it forms a benign growth; if its tissues fail to mature completely but continue to proliferate at embryonic level it may result in a malignant growth. Gross[12]

reported four cases of pulmonary metastasis in 40 cases of sacrococcygeal teratoma.

Early surgical removal of the tumor is recommended by all authors.[12-14] The results of this treatment are encouraging. Gross mentioned that of 40 cases treated surgically, 29 were presumed cured.

Summary

A case of sacrococcygeal teratoma in a newborn infant is reported. This tumor often complicates delivery, leads to erroneous diagnosis, and may result in the death of the infant. In most cases, the tumor is amenable to surgical treatment.

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CONTROL OF THROMBOEMBOLIC COMPLICATIONS. — Either dipyridamole, a vasodilator known to reduce platelate adhesiveness and aggregation, or a placebo was given in a daily dose of 400 mg as a random, blind trial to 70 patients who had undergone prosthetic cardiac-valve replacement. Patients in both groups were given anticoagulation with warfarin sodium. Of 36 patients in the placebo group followed for 557 months systemic arterial embolism occurred in 17 per cent. Twenty-seven patients in the dipyridamole group followed for 393 months gave no clinical evidence of arterial embolism. Dipyridamole was discontinued shortly after surgery in seven patients, and these were followed for 110 months. In two of them cerebral emboli developed six months after treatment was discontinued. It is tentatively concluded that the addition of dipyridamole to a program of anticoagulation reduces the frequency of postoperative arterial emboli originating on prosthetic cardiac valves in patients who can tolerate the drug. — Jay M. Sullivan, M. D., Dwight E. Harken, M. D., and Richard Gorlin, M. D., Boston: *The New England Journal of Medicine*, 279:576-580, Sept. 12, 1968.



NEWS AND Organization Section

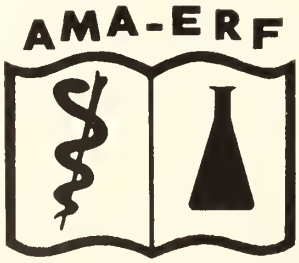
Ohio Kick-Off for AMA-ERF Campaign...

Loan Guarantee Programs and Biomedical Research Stressed As Ohioans are Urged to Make Contributions to the AMA-ERF

OHIO's ANNUAL CAMPAIGN in behalf of the American Medical Association Education and Research Foundation is now underway to make it possible for Medical Education Loan Guarantee Programs and Biomedical Research. Dr. Robert S. Martin, Zanesville, is chairman of the Ohio AMA-ERF Committee, which is composed of the chairman and the 11 District Councilors of the Ohio State Medical Association.

We, as physicians, are trustees of medical knowledge and skills. This imposes a responsibilty on us to help materially in the areas of Medical Education and Medical Research.

Your American Medical Association Education and Research Foundation is an effective means through which you, individually, can provide support.



Here is what your Foundation is doing:

- $18,677.00 has been given through the Foundation as unrestricted Funds for Medical Schools. Reports of all individual designated contributions are sent to the medical schools. Ohio medical schools received $40,994.14 from AMA-ERF in 1967.



Dr. Martin

- The Institute for Biomedical Research has in three years of operation gained worldwide recognition as a center of excellence delving into basic life processes.

- 19,000 medical students, interns, and residents now have $45,000,000 on loan through the Student Loan Guarantee Fund.

All of this has been done by the private sector of the economy without government subsidy. This is an enviable record; but it needs to be even better.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Martin, members of the 1967 Ohio AMA-ERF Committee, and the local chairmen urge Ohio physicians to respond generously in this year's campaign.

OSMA Sponsors In-Hospital Indemnity Protection For Members, Their Families, and Employees

DURING the past year and a half,, the Committee on Insurance of the Ohio State Medical Association has considered a number of different approaches aimed at providing members with more flexible and broader insurance protection.

Guaranteed Issue

After reviewing a number of proposals, the Committee recommended on May 26, 1968, adoption of a guaranteed issue program providing liberal in-hospital indemnity benefits to members and their dependents and employees of members and their dependents.

This new program was approved by The Council of OSMA at its meeting on September 15, 1968.

Careful consideration of this supplemental protection is recommended to members who have received notice of it through the mail and will be receiving further information.

Charter Enrollment Now Open

During this initial Charter Enrollment Period, all members of the Ohio State Medical Association under age 70 who apply are guaranteed issuance of this supplemental protection regardless of past medical history. After the Charter Enrollment Period expires, enrollments can be received only from members, or employees, under the age of 60.

Preexisting Conditions Covered

Coverage is provided for preexisting conditions after the insured has gone through a period of 12 consecutive months or more without medical advice or treatment for that condition.

Tax Free Benefits

One of the advantages of this type coverage is that it can be used to supplement any kind of hospitalization insurance since it provides a fixed amount of dollar indemnity per day of hospitalization regardless of whether or not the insured has other protection. Thus, it can be used to cover any deductible that may be present, to cover any coinsurance factor normally paid by the insured, to help pay nursing care, or any other purpose. Actually, an insured can use his indemnity for any purpose at all, including paying household expenses, as a partial income replacement, or can just put it in the bank if he pleases. Payments made are income tax free under present federal income tax law.

Convenient Supplement

This new plan is available to all members, whether or not they are already covered under the OSMA Major Medical Program. The administrators recommend that a member protect himself and his dependents, under the OSMA Major Medical Program and supplement it with this new In-Hospital Indemnity Plan. Administrators for both plans are Daniels-Head & Associates, Inc., Portsmouth, Ohio. Since the same firm administers both plans, claims payment procedure would be somewhat simplified if one were protected under both of these plans inasmuch as a single claim form could be used to collect benefits from both plans.

Employees Also Eligible

Employees under age 70, and their dependents, are also guaranteed issuance of this protection if they apply now.

In this issue of *The Journal,* another article announces new benefits available to those insured under the OSMA Major Medical Insurance Program.

"Education for Family Practice" Booklet Issued by OAGP

"Education for Family Practice" is the title of a booklet recently published by the Ohio Academy of General Practice. It is a compilation, bringing under one cover transcripts and extracts of addresses presented at the Education for Family Practice seminar held in Columbus, April 24-25, 1968.

Co-sponsors of the seminar included the Ohio State Medical Association and Ohio's four medical schools.

Background of the seminar is explained in a Foreword by Tennyson Williams, M. D., Delaware, chairman of the OAGP Medical School Family Practice Committee.

Of special significance is the paper entitled "The Role of the University in Education for Family Practice" by Robert J. Haggerty, M. D., professor and chairman, Department of Pediatrics, University of Rochester School of Medicine.

Under the same general heading of "Whose Responsibility," Warren G. Harding, M. D., administrator of Grant Hospital, Columbus, presents a paper on "The Role of Community Hospitals."

Other topics and author-speakers are:

"Introduction" — Arthur D. Nelson, M. D., executive director, Temple University Hospital, Philadelphia.

"The Crisis in Family Health Care" — E. Grey Dimond, M. D., professor of medicine in residence, Scripps Clinic & Research Foundation, La Jolla, Calif.

"Education for Family Practice — Undergraduate" — Lynn P. Carmichael, M. D., director, Division of Family Medicine, University of Miami School of Medicine.

"Education for Family Practice — Graduate" — George E. Burket, Jr., M. D., president, American Academy of General Practice, Kingman, Kansas.

"Education for Family Practice — Continuing Education" — Joel J. Alpert, M. D., director, Family Health Care Program, Harvard Medical School.

"Family Practice in New England — An Evaluation" (extract) — J. Whitney Brown, M. D., instructor in pediatrics, Harvard Medical School.

"The Abandoned Patient" — Mrs. Anne Somers, research associate, Industrial Relations Section, Princeton University.

"The Role of Preceptorship" — Nicholas J. Pisacano, M. D., Lexington, Ky.

Also included are notes on discussion groups: (1) The Future of Family Practice; (2) Undergraduate Education for Family Practice; (3) Graduate Education for Family Practice; (4) Continuing Education for Family Practice; and (5) Collaborative Research.

The conference summary is presented by Vernon Wilson, M. D., executive director, Health Affairs, University of Missouri.

Copies of the booklet may be obtained by writing the Ohio Academy of General Practice, 4075 N. High Street, Columbus 43214.

National Family Health Week Set for November 17-23

President Johnson on September 18 signed the joint House/Senate Resolution designating the week of November 17-23, 1968 as "National Family Health Week."

The Resolution requested the President to proclaim the week "as a means of focusing national attention during the year upon the accomplishments of the American health care system and the central role played by the family physician in the maintenance of superior medical care for Americans of all ages and from all walks of life."

Senator Ernest Gruening of Alaska and Representative Tim Lee Carter of Kentucky (both physicians) introduced the legislation at the request of The American Academy of General Practice.

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Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupil tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported wit Lomotil therapy include nausea, sedation, dizzines vomiting, pruritus, restlessness, abdominal discor fort, headache, angioneurotic edema, giant urticari lethargy, anorexia, numbness of the extremitie atropine effects, swelling of the gums, euphori depression and malaise. Respiratory depression an coma may occur with overdosage.

Dosage: The recommended initial daily dosage given in divided doses until diarrhea is controlle are as follows:

liarrheas...



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Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

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yr. . . . . 1 tsp. q.i.d. (8 mg.)
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on 4 cc. per teaspoonful.

tenance dosage may be as low ne-fourth the initial daily dosage.

References:

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New Outlooks in Public Health . . .

State Health Director Stresses Greater Responsibilities And More Opportunities Opening in Public Health Field

EMPHASIS WAS PLACED ON new outlooks, new responsibilities, and new opportunities in the public health field in the annual report given by Dr. Emmett W. Arnold, director of the Ohio Department of Health, before the 49th Annual Conference of Ohio Health Commissioners on September 11 and 12 in Columbus.

The annual conference, an official state function, was held in conjunction with the annual meeting of the Association of Ohio Health Commissioners, a voluntary organization.

Dr. Harry Wain, Mansfield, was installed as president of the Association of Ohio Health Commissioners, to succeed Dr. Ollie M. Goodloe, of Columbus. Dr. Hilbert Mark, Toledo, was named president-elect, and Dr. Mary R. Boyd, Wilmington, secretary-treasurer. Dr. Harold P. May, Delaware, and Dr. Harold G. Curtis, Cleveland were named members of the executive committee. Mr. E. A. Graber, 1429 King Avenue, Columbus 43212, is executive secretary.

Uppermost in topics of discussion at the meeting were comprehensive health planning as it applies to local health departments, environmental health planning especially in regard to disposition of solid wastes, and financing of local health departments with emphasis on state subsidies.

Among guests at the meeting was Dr. Theodore L. Light, Dayton, President of the Ohio State Medical Association, who spoke briefly, emphasizing the fields of common interest between practicing physicians of the state and health officers.

Following are excerpts of Dr. Arnold's address before the health commissioners.

Comprehensive Health Planning

Since last year's meeting of this Conference, the Office of Comprehensive Health Planning has been established and staffed in our Department. The Ohio Advisory Council to this program has been created and its membership named. The Council has met and has begun consideration of the major work facing it, giving its approval to a Revised State Plan for 1969 which will include the development of subcommittees for environmental health, mental health and retardation, rehabilitation, health manpower, and health facilities.

Our State Office of Comprehensive Health Planning has given a major portion of its time in assistance to communities throughout Ohio in establishing areawide health planning agencies. Approximately 85 percent of the population of Ohio is covered by the areawide comprehensive health planning agencies now developing. Two of these areawide agencies have been funded. Ten others are completing grant applications.

We are pleased that local health departments have provided much leadership in the development of areawide health planning agencies. . . .

Our Ohio Office of Comprehensive Health Planning will continue to place high priority on assistance in the establishing of areawide planning agencies. It will work closely with the Ohio Advisory Council in the organization of subcommittees and task forces, the development of guidelines and policies, and the review of areawide planning applications. . . .

We are preparing a statewide in-service training program for health planning personnel. We are recruiting additional staff for our Office of Comprehensive Health Planning to staff the special subcommittees of the Advisory Council and to work with the areawide planning agencies throughout the state. We already have added a field training coordinator and an environmental health coordinator. Others being considered are specialists in such fields as mental health, retardation and rehabilitation. . . .

Administration and Financing

Local health departments in Ohio, city and county, operated on budgets totaling $20,456,847 in fiscal 1968. This was an increase of about $1 million over the previous year — a gain, but not as large as gains shown in 1967 and 1966. Total increases for the last three years, however, are more than $4½ million, a greater than 25 per cent boost in a relatively short time, showing a definitely growing public support for our health departments.

Eight county health departments had successful health levies on the ballot in November, 1967. Seven more health levies were approved by voters in May, 1968 — first opportunity of general health districts to present such levies in primary elections. In the November, 1968, election, 14 counties will have public health levies on the ballot. This, of course,

is not the only way of financing local health programs, but it is one which pointedly demonstrates whether popular support and understanding have been developed. . . .

In the operation of local health departments, 18 health commissioners resigned during the past year and 21 health commissioners were employed by local departments. At the present time there are 133 local health commissioners serving in Ohio and nine vacant health commissioner posts. We have a total of 286 health districts — 88 county and 198 city. Many of these have been combined by merger or contract.

Several local health departments have been constructing or are about to construct their own health department buildings, with Hill-Burton aid through our Medical Facilities Division. New facilities include those for Defiance County, Lorain County, and the Springfield City-Clark County combination. Carryover projects under way are those for Akron, Cincinnati, Belmont County, Harrison County, and the Cleveland Westside Unit. New health centers are scheduled for Jackson and Montgomery Counties.

During the past year, our Medical Facilities Division scheduled more than $12,400,000 in grants to aid construction of 27 projects throughout the state, including hospitals, extended care units, nursing homes, and rehabilitation centers as well as health centers. It has a current waiting list of 78 requests involving more than $250 million in total construction of hospitals and other medical facilities.

In this connection, the handling of packaged disaster hospitals has taken a new direction in the past year. Our Health Mobilization Unit is seeking to affiliate the storage, maintenance, supervision and possible emergency use of these disaster hospital packaged units with existing community hospitals. A total of 63 community hospitals have signed formal agreements for such affiliation. Ohio leads all the states in the number of such agreements to date. We also are in process of changing the old Packaged Disaster Hospitals for the new 10-M Packaged Disaster Hospitals, developed by the federal government, which are a considerable improvement on the older units. We have received 26 of the new units to date, and expect about 25 more new units in the coming year. Iit is our hope eventually to have 150 community hospitals affiliated with this program.

Our Health Mobilization Unit's medical self-help training program is being expanded. For example, in the single month of May, 1968, a total of 50,795 persons were trained in this part of our emergency care program. This was more than in any previous whole year of this five-year-old project. A total of 124,755 received this training in fiscal 1968. A total of 284,961 Ohioans have had the training since the program started in 1963.

With respect to emergencies, we have a new project just about to get started. It is an Emergency Medical Services Coordinating Program, which will seek first to develop reliable information for the whole state on the availability of such facilities as ambulance service, hospital emergency rooms, emergency squads and related services — information which is sketchily unsatisfactory at this time. . . .

At the state level, Ohio Department of Health operations for the past fiscal year cost $8,483,394. This included the operating costs of the two state tuberculosis hospitals, one on the Ohio State University campus and one at Nelsonville.

Disease Control and Research

We continue to be concerned about the fact that Ohio has had a higher number of reported and confirmed cases of California type encephalitis than any other state. Recognizing that this difference may be credited in part to more intensive study and better reporting in Ohio, it still gives us justification for continued research and investigation.

During the period of 1964 through 1967, we have had 131 cases of identified California Encephalitis Virus infection. . . .

In our field research, we have identified five types of aedes mosquitoes in Ohio as vectors of California encephalitis virus. . . .

A new project in our Epidemiology Section is a planned intensive study of the Congenital Rubella Syndrome. As you know, we may soon have a satisfactory immunization for rubella, the so-called German measles. . . .

In the field of tuberculosis control, we continue to note improvements related to our intensified programs aimed at eventual eradication. There was a 21 per cent reduction in the number of tuberculosis patients in tuberculosis hospitals in the year from July 1, 1967, to June 30, 1968. In line with 1966 legislation, 78 of the 88 counties now have tuberculosis. . . . We currently have 19,430 cases on our state tuberculosis register, including both active and inactive cases under surveillance. Of these, there were 840 active cases in tuberculosis hospitals at the most recent count.

Another new research project in our Communicable Diseases Division is a pesticides study, tied in with a national project of the United States Communicable Disease Center in Atlanta, Georgia. We shall be determining the levels of pesticides in the water, in the air, and in humans. . . .

Other Health Services

Heart disease remains the number one killer in Ohio, as it is in the nation. Rheumatic fever is one of the significant causes of heart disease. There is increasing emphasis on primary prevention of

rheumatic fever by taking throat cultures of youngsters ill with sore throats, and follow up immediate antibiotic treatment for those with strep infection (Group A—Beta Hemolytic streptococcus). We are stepping up the pace of such cultures. During 1967, there were 150,000 processed in the entire year. In the first seven months of 1968, more than 100,000 were processed. The Ohio death rate due to rheumatic fever is dropping. It was 17.6 per 100,000 population in 1950. It was down to 7.9 per 100,000 in 1966, the most recent year with complete tabulation — a very significant drop.

Community diabetes screening was continued this year in a number of Ohio counties, with the aid of the State Health Department. We have been finding an average of 11.5 new cases among each 1,000 persons examined, indicating the need for continuing and expanding this program.

During the past year, our Chronic Disease Division conducted an experiment in multiple screening — including blood tests, x-rays, pulmonary function tests, visual acuity, glaucoma, and hearing tests. Screenees were adults ranging from 19 to 69 years of age, 43 per cent male and 57 per cent female. Among those checked, 65 per cent showed one or more abnormalities, which were referred to their own physicians. . . .

These expanding programs — such as rheumatic fever, diabetes surveys and multiple screening — continue to throw a greater burden on our State Health Laboratory. We are very happy to report that specific planning is being made for a new laboratory to be located at Eighth Avenue and Perry Street on the Ohio State University Campus, about two blocks from the present laboratory. This is vitally needed and a most welcome development. The new laboratory will have some 60,000 square feet of floor space.

We have a new Advisory Board to our Bureau of Laboratories.

Included in the heavy load of analyses of all kinds run in our Laboratory are the phenylketonuria tests for newborn infants. More than 170,000 of these were run in the past year. There were 15 confirmed cases of phenylketonuria in 1967. Since the initiation of this program, 79 positive PKU cases have been found and placed under appropriate care. . . .

In our Division of Maternal and Child Health, all programs have expanded substantially over the last several years. We note particularly an expansion of clinic services of various types throughout the state, and there is growing emphasis on family planning services. At the present time, 22 counties have family planning clinics. Four of these are located in health departments — the remainder are associated with voluntary agencies. . . .

There are maternity clinics now in 14 counties — but none in what might be considered truly rural counties. . . .

In a related program, classes in "preparation for parenthood" now are offered in 36 counties. . . .

With respect to infant and child care, two more counties have developed child health clinics, bringing the total to 33. We have seen an increasing desire to provide more and better school health services for the children of Ohio. Our Division of Maternal and Child Health assists the State Department of Education in establishing school health policies, evaluating school health programs, training teachers, school nurses, and other school personnel through in-service education and school health workshops. . . .

A relatively new program in our Department is the auditory screening of newborn infants. We have an on-going program for training in the techniques of this work. . . .

The fact that many young people go through their entire school years with serious correctible defects has been clearly shown in the work of our Health



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Referral Unit. Under this program, established in early 1966, we have had interviewers at the three Armed Services Examining Stations in Ohio. Here are some of the reports from their efforts: 35 per cent of the young men appearing at these stations have been disqualified because they had at least one medically disqualifying defect. We were able to interview about 90 per cent of those rejected. Of those interviewed, 95 per cent wanted further counseling and help. They were referred to local health departments for additional guidance and for follow-up, usually with private medical care. In broad categories we have found the prevalent defects to be in the areas of eye disease (30 per cent), nutritional-obesity (15 per cent), diseases of bone and organs of movement (15 per cent), circulatory (8 per cent) and digestive (6 per cent). While continuing our work of guidance to individuals in this program, we also are taking advantage of the opportunity in it for health research.

Our certification program in cooperation with Medicare continues to demand much time and effort in consultations on bringing facilities up to standards. . . .

The Nutrition Unit in our Department was raised to Divisional status during the past year. One of its important new efforts is the organization of refresher courses for dietitians who are interested in returning to work after being inactive for a number of years. . . .

Our Nursing Division, of course, also is placing special emphasis on recruitment, refresher courses and other training programs to improve the availability of critically needed nursing personnel. . . .

There are still 22 counties which lack home health services—and three of the 22 have a high rate of population in the over-65 age group. However, it is gratifying that the counties with home health agencies for patient care covers more than 91 per cent of the Ohio population. . . .

Alcoholism services are expending in Ohio. There now are 18 local programs, which got under way with grant-in-aid assistance from the State Health Department. . . .

A related but totally separate program is our certification project for alcohol testing of motorists. In the less-than-one-year that we have been involved in this project, associated with general traffic safety, our Department has certified 44 laboratory directors, 61 laboratory technicians, 240 senior operators and 2,100 operators for use of measuring equipment to determine alcohol levels in the human body. A new manual on alcohol testing is in preparation at this time.

The Ohio Education Program on Smoking and Health is now functioning in 28 counties which have somewhat more than 50 per cent of the State's population. . . .

Environmental Health

A landmark in the field of environmental control is the new solid wastes disposal law passed by the Legislature in 1967 and becoming fully effective on January 1, 1969. Regulations under this law have been adopted by the Ohio Public Health Council. Local health departments have the opportunity of conducting the licensing and enforcement phases of this program. To assist local efforts, we have held some 20 training sessions for local health department personnel this year.

In air pollution control, we have a new program and a new State Air Pollution Control Board. In its meetings thus far, the new Board has taken preliminary steps toward the eventual setting of regional air quality standards. This program ties in with the Federal Clean Air Act, which also calls for the establishment of air pollution control regions throughout the country. It appears that the philosophy of the Ohio law and the federal act are basically the same and will complement each other. . . .

In the research field, we have continued the operation of the Ohio Air Sampling Network. . . .

Water Pollution Control efforts in the past year have moved forward with the setting of new stream quality standards in more areas of the state. . . .

We are about ready for another important step in our radiological health program. We have been conducting a surveillance and registration program under legislation adopted seven years ago. . . .

In the field of general sanitation, we think that local health officials will be interested in cost studies made by our Sanitation Division in connection with the supervision and enforcement of milk, food service, vending machine and on-lot-sewage inspection programs. At the present time, local departments are collecting about $1\frac{1}{2}$ million annually for license and inspection fees in these programs.

Accidental injuries continue as a truly major problem in Ohio.

Legislative Outlook

It is admittedly early to be making forecasts of prospective legislation for the 1969 session of the Ohio General Assembly. There are, however, some obvious problems which need attention. These may be added to proposals which are receiving attention of interested groups at this time. Together they form an indication of legislation which may be presented for consideration. We are not offering these items specifically as a program of the Department, but rather as items which deserve your serious consideration now since they may be appearing as legislative bills in the next few months.

One is a proposal to revise the compulsory immunization law for school children to include immuniza-

tion against measles—rubeola—along with polio, diphtheria, whooping cough, tetanus, and smallpox.

Another is a proposal to have compulsory tuberculosis tests in the schools—for school employees and for students.

It is quite likely that a statewide law for fluoridation of public water supplies will be proposed. Working city by city, we are making some progress in this program, but very slowly. Only about 41 per cent of the Ohio population served by municipal water systems have water with optimum fluoride levels. Ohio now ranks 31st among the states in this situation. Statewide legislative action for adequate fluoridation of water supplies has been adopted in Michigan, Massachusetts, Delaware, Illinois, Connecticut, and Minnesota.

There is a suggestion for up-dating the law which permits fees for public health nurses making health care calls on the sick at home so that it will be clearly applicable to such other health personnel as therapists and dietitians.

A law is in the offing for the licensure of nursing home administrators in order to comply with federal programs and requirements. State licensure of hospitals and clinical laboratories also may be pushed by the prospect of federal requirements under Medicare.

Some up-dating of the Ohio plumbing code is likely—particularly in clarification of sections.

Clarification also seems to be needed with respect to the state's special sanitary districts, such as those around the state-owned lakes. The split in responsibility among the state, counties, and municipalities in such cases is not satisfactorily understood.

A statewide law for supervision and control of on-lot water and sewer systems seems to be needed. This could be administered by local health departments, with state supervision and evaluation as in food service, solid waste disposal and other programs. What we need is uniformity and assured enforcement.

These, of course, are just a few of the legislative possibilities for next year, but they are enough to indicate a need for our concern and close attention.

Dean Is Appointed for Medical College at Toledo

The appointment of Robert G. Page, M. D., as Dean of the Medical College of Ohio at Toledo has been announced by President Glidden L. Brooks, M. D. Dr. Page was formerly Associate Dean, the Division of the Biological Sciences, the University of Chicago. He joined the College on August 19, 1968.



Dr. Page

Dr. Page holds a Bachelor of Arts Degree from Princeton University and a Doctor of Medicine Degree from The University of Pennsylvania Medical School. He has served on numerous university committees involving curriculum planning, admission, and precollegiate education.

Dr. Page is a member of the American Association for the Advancement of Science, American College of Physicians, American Federation for Clinical Research, American Heart Association, American Medical Association, American Society for Pharmacology and Experimental Therapeutics, Association of American Medical Colleges, and the New York Academy of Science.

He is married and the father of three children. The family residence is at 4206 Bonnie Brae Circle, Ottawa Hills, Toledo.

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New Benefits for OSMA Members Under Major Medical Insurance Program

WITH THE COST of hospital care rising, it is gratifying for the Ohio State Medical Association to announce to its members that their Major Medical Insurance Program will give added benefits, at no added cost, as of December 1, 1968.

Many claims of substantial size have been paid under this program since it began five years ago. The loss ratio during the first two years was exceedingly heavy and ran more than 100 per cent of premium. During the past three years the group's loss experience has been more favorable. Recognizing this favorable trend, the administrator, Daniels-Head & Associates, Inc., of Portsmouth, negotiated with the Insurance Company of North America for certain improvements in the plan.

Improved Benefits

These improvements were presented to the Committee on Insurance this past May, were approved, and were subsequently endorsed by The Council.

Accordingly, OSMA policyholders will be entitled to the following "bonus benefits" as of December 1, 1968, which increase their protection at no extra premium:

1. The previous maximum hospital room and board rate of $37.50 per day (80 per cent of which is covered) will be increased to $45 per day, and will be increased to $60 per day where intensive care is prescribed by an insured's attending physician.

2. Policyholders over age 65 will be covered under the much broader $300 deductible plan at the lower premium rates previously charged for the $1,000 deductible plan.

3. In recognition of the financial problems of younger new members commencing practice, the normal premium for the $500 deductible plan will be drastically reduced during the first year of membership in the Ohio State Medical Association, **provided that** the member applies within 60 days of becoming a member. Coverage issued to new members under age 40 applying within the first 60 days of becoming a member will be guaranteed to the member regardless of his insurability, with his dependents subject to normal underwriting requirements.

It should be noted that the above increased maximum limits for hospital room and board are available to all insureds regardless of age. All members of the Ohio State Medical Association not already covered under the Association sponsored Major Medical Program are urged to consider this coverage. It has proven to be of great importance to many of those insured who have experienced major illnesses or injuries. Once insured, coverage can be continued for life as long as the member remains in good standing with the Ohio State Medical Association and pays premiums when due, even after retirement.

Participation Important

It is of particular importance to all members that they take advantage of this program and apply for this broad protection while they remain insurable and while other family members can be accepted and included in their protection.

Many Claims Paid

It is interesting to note that more than 1,000 claims have been paid in less than five years. Of these claims, approximately 60 per cent have involved the member himself with approximately 30 per cent involving the spouse of the member and approximately 10 per cent involving dependent children, the administrators report.

Supplemental Protection Announced

A new program of In-Hospital Indemnity Coverage has also been approved by The Council of the Ohio State Medical Association and is now in the process of being offered to members. Another article on this new program is contained elsewhere in this issue of *The Journal*. The combination of coverage under the new In-Hospital Indemnity Plan together with the OSMA sponsored Major Medical Program makes it possible for members to have broad and liberal coverage at a relatively low cost and with a more than normal stability.

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Outstanding Scientific Exhibits At OSMA Annual Meeting

SCIENTIFIC EXHIBITS provided important features of the 1968 OSMA Annual Meeting in Cincinnati, May 13-17. Out of some 40 Scientific Exhibits, a judging team selected several as outstanding. This procedure was in keeping with recommendations of the Committee on Scientific Work approved by The Council. The authorized award in each case included a certificate of recognition, and permanent type plaque. A summary of exhibits selected to receive recognition was printed in the July issue of *The Journal*. Following are brief descriptions of some of the award winners. Other summaries were published in the September and October *Journals*, and more will be published in the future.

* * *

Bronze Award Goes to Exhibit on Caged Lens Heart Valve

The exhibit entitled "Caged Lens Heart Valve," sponsored by Frederick S. Cross, M. D., Ph. D., and Richard D. Jones, Ph. D., Division of Surgery, St. Luke's Hospital, Cleveland, received the Bronze Award in the Field of Original Investigation.

Sponsors provided *The Journal* with the following description of the exhibit and the investigation involved.

The concept of a free floating, caged lens valve prosthesis is now well accepted, particularly for mitral valve replacement. The chief advantage of the lens valve is its low profile compared to a ball valve. This is important in mitral valve replacement and is especially advantageous in the patient with a small left ventricle. The Cross-Jones valve is a lens valve consisting of a machined titanium open end cage, a Teflon attachment ring, and silicone rubber lens. A thin titanium ring is incorporated in the lens to prevent its extrusion from the cage. The valve is designed so that the frustum or outflow area is 20 per cent greater than the inflow area to assure free flow across the valve.

The lens valve is less than half the height of the ball valve making it superior for use in the mitral area. Because of the low profile design of the valve, cardiac irregularities caused by irritation of the myocardium by the cage are avoided as is aortic outflow tract obstruction sometimes seen with ball valves.

Ball and lens valves have been tested in a mechanical ventricle and functional superiority of the lens valve over the ball valve has been demonstrated. At pulse rates of 80/minute (5.6 liters/minute) the opening lag of the lens is one half that of the ball. Likewise, the lens closes in half the time that it takes the ball, and there is less oscillation and bouncing of the lens. Finally, the lens strikes the valve seat with less force during closing than does the ball. All of these advantages add up to a quicker acting, quiet valve with less demonstrable regurgitation across the valve. This superior action results from the light weight of the lens and its short travel distance.

Over 2000 Cross-Jones valves have been sold since January, 1965. There have been no reports of abnormal lens wear or fixed cocking of the lens in valves in which lens movement remains unobstructed. Mechanical testing in a pulse duplicator has shown that the valve frame and lens is resistant to wear over the equivalent of 15 years.

The first valve was placed in a human subject in January, 1965, and is functioning normally without complications to the present time. A follow-up series of 224 valves in 214 patients for periods up to 3½ years has been collected. The early mortality has been 11.5 per cent and the late mortality 12.5 per cent. The majority of deaths were due to the underlying cardiac problems rather than to complications of the valves. The long-term incidence of thromboembolic problems has been 9 per cent, many of these occurring in patients not on anticoagulant therapy.

Current laboratory studies are directed at design changes to decrease the incidence of thromboembolic complications from the valve. These studies have resulted in a valve with the rim totally covered with wide mesh Dacron for better tissue ingrowth. This valve is available for clinical use.

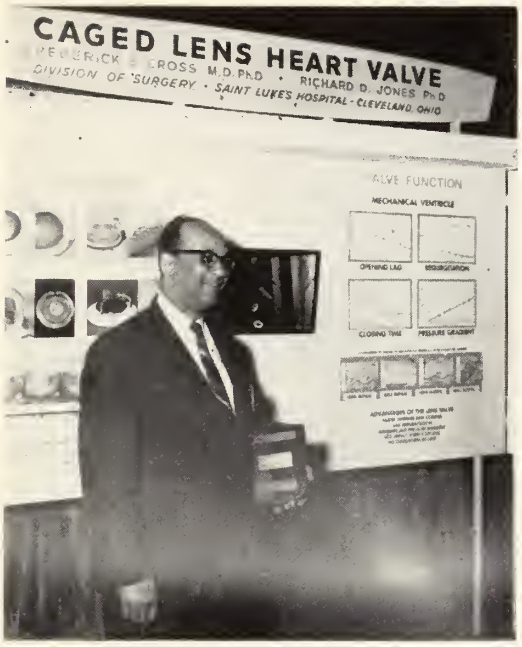
* * *

Exhibit on Differential Diagnosis Of Leg Ulcers Given Award

The Bronze Award in the Teaching Field was presented to sponsors of the Exhibit entitled "Leg Ulcers — Differential Diagnosis and Treatment." Sponsors were Henry H. Roenigk, Jr., M. D., Depart-

Outstanding

ANNUAL MEETING EXHIBITS



Bronze Award
in Original Investigation
"Caged Lens Heart Valve"



Bronze Award
in Teaching Field
"Leg Ulcers — Differential
Diagnosis and Treatment



Honorable Mention
in Teaching Field
"Teaching Urinalysis"

ment of Dermatology, and Jess R. Young, M. D., Department of Peripheral Vascular Disease, Cleveland Clinic.

In addition to its selection as outstanding by the Ohio State Medical Association, this exhibit has received the following other awards and honors:

Samuel Becker Gold Award for Exhibit with highest Teaching Value — American Academy of Dermatology, Chicago, Illinois, December, 1967.

Billings Bronze Award for Teaching — American Medical Association, San Francisco, California, June, 1968.

Best Scientific Exhibit — Ohio Academy of General Practice, Dayton, July, 1968.

Sponsors described the exhibit and the information represented by it as follows:

Establishing the correct etiologic factors in chronic leg ulcers is essential to proper management of this very common problem. This exhibit prepared jointly by the Departments of Dermatology and Peripheral Vascular Disease of the Cleveland Clinic attempted to present a reasonable classification of different types of leg ulcers in a manner which will help the practicing physician in correctly diagnosing and treating leg ulcers.

Many leg ulcers will have characteristic features and history, physical examination and laboratory studies will help to establish the correct diagnosis. It is important to ask the following questions and consider the accompanying notes:

1. What did the ulcer look like at first? Ulcers may change appearance with infection and local medication.

2. What started the ulcer? Local injury, irritating medications, infection, exposure to cold, insect bites, self-induced lesions or any underlying systemic disease?

3. What is the family history and racial background?

4. How quickly did the ulcer develop? Rapidly developing ulcers suggest venous insufficiency. Slower ulcers suggest arterial insufficiency or malignancy.

5. How painful is it? Stasis ulcers are often painless. On the other hand, arterial ulcers are very painful and the patient will sit in a chair because elevation of the leg causes extreme pain due to ischemia. Venous ulcers are relieved by bed rest.

6. Where is the ulcer? Ulcers due to stasis dermatitis are often over the internal malleolus because the area is drained by the saphenous system. Ischemic ulcers occur on areas farthest from the heart, common locations are the toes and feet. Hypertensive ulcers tend to occur on the lateral malleolus.

7. What is the condition of the surrounding skin? Look for stasis pigmentation, edema, pressure or absence of arterial pulsations, evidence of scleroderma, petechia, etc.

Appropriate laboratory studies should always include a complete blood count, serological tests for syphilis, urinalysis, bacterial smears and cultures (including acid-fast), mycology cultures, and a skin biopsy.

Some 43 slides were presented as part of the exhibit display and visiting physicians were invited to test their abilities to make diagnoses by clinical observations alone. A reprint listing leg ulcers by classification with brief notes was made available to visitors. This reprint is still available and a copy may be obtained by writing to the sponsors at the Cleveland Clinic.

* * *

Honorable Mention Goes to Exhibit On "Teaching Urinalysis"

The exhibit entitled "Teaching Urinalysis," sponsored by Arthur T. Evans, M. D., and Robert Helmling, M. D., Department of Urology, University of Cincinnati College of Medicine, was given Honorable Mention as one of the outstanding presentations.

This exhibit depicted in graphic form the various steps in urinalysis and how the procedure is presented as part of the teaching program. Photomicrographs of urinary sediment in color indicated procedure for gross examination.

Included as a feature of the exhibit was a projector and screen on which some 80 colored slides were projected for alternate viewing. A tape recorded message accompanied showing of the slides.

This exhibit previously had won First Prize in the Teaching Field at last year's meeting of the American Urological Association.

Stouffer Award Honors Researchers For Blood Chemistry Studies

Four researchers shared this year's Stouffer Award, including a $50,000 cash prize, established by Vernon Stouffer, head of an extensive food service group. Dr. Irvine Page, Cleveland, is chairman of the prize selection committee. Awards were presented at a meeting on high blood pressure research, October 4.

The four men selected have all made outstanding contributions to research on angiotensin and its relationship to blood pressure. They are:

F. Merlin Bumpus, Ph. D., chairman and director of the Cleveland Clinic Foundation Research Division.

Leonard T. Skeggs, Ph. D., codirector of the Hypertension Research Laboratory, Cleveland Veterans Administration Hospital.

Robert Schwyzer, head of the Department of Microbiology, Swiss Federal Institute of Technology in Zurich.

William Stanley Peart, M. D., professor of medicine at St. Mary's Hospital, London, England.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1969 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, Ohio, May 12-16

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

   _____

   Institution (if desired): _____

   City _____

3. Do you have a built-in exhibit? _____

4. Description of Exhibit: (Attach 200 word description to this blank)

5. Exhibit will consist of the following: (Check which)

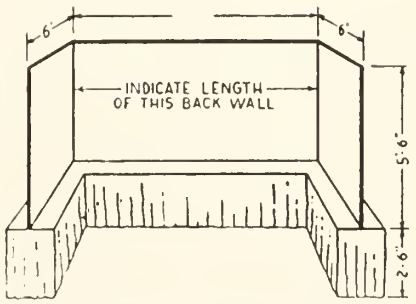
   Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

   Specimens _____ Moulages _____ Other material _____
   (Describe)

6. Booth Requirements: (See Sketch)

   Back wall _____ All sidewalls are 6′ deep
   (Indicate Footage)

   Shelving: Shelves are 12 inches deep at a height of 2 feet 6 inches from the floor. Please indicate if you require shelves (yes or no) _____.



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

7. Transparency Cases:

   Needed? (yes or no) _____
   If answer "yes," give following information:
   Number of transparencies to be shown and size of each

   _____

   _____

   _____

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date _____

_____
Signature of Applicant

_____
Mailing Address, Street

_____
City, State, Zip Code

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC WORK, OHIO STATE MEDICAL ASSOCIATION, 17 SOUTH HIGH STREET, SUITE 500, COLUMBUS, OHIO 43215

Deadline For Filing Applications, January 30, 1969

Ad Astra

Charles Ambrose Bayer, M. D., Toledo; St. Louis University School of Medicine, 1932; aged 66; died September 16; member of the Ohio State Medical Association and the American Medical Association. A native of Perrysburg and resident of the Toledo area for most of his life, Dr. Bayer specialized in obstetrics. A lifelong interest in sports developed out of his early career as a professional boxer. Another interest was operation of a wildlife sanctuary on his estate. Affiliations included memberships in the Catholic Church and the Catholic Physicians Guild. Surviving are his widow, a daughter, two sons, two sisters, and three brothers.

George A. Boon, M. D., Oak Harbor; McGill University Faculty of Medicine, Montreal, 1923; aged 69; died September 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Boon practiced for some 42 years in the Oak Harbor vicinity. A native of Canada, he served in the Canadian Air Force during World War I and later served in the U. S. Army reserve. He was a member of the Methodist Church, several Masonic bodies, and an honorary member of the Rotary Club. Among survivors are his widow, two sons, a daughter, his mother, and a sister.

Charles Albert Bowers, M. D., Cleveland; Johns Hopkins University School of Medicine, 1912; aged 84; died September 27; member of the Ohio State Medical Association, the American Medical Association, and the American Urological Association; Fellow of the American College of Surgeons; diplomate of the American Board of Urology and of the American Board of Surgery. A surgeon and urologist of long standing in Cleveland, Dr. Bowers was active in many community affairs. He was a member of the Lakeside Hospital Unit of World War I and served as a lieutenant colonel in the Army during World War II. He received the "man of the year" award from both the national and state societies for crippled children for his work in that field. For many years he was president of the Shaker Heights school board. He was a former president of the Rotary Club, a 33rd Degree Mason, and a member of the United Church of Christ. Survivors include his widow, a daughter, and two sons.

Edgar Louis Braunlin, M. D., Dayton and Miamisburg; University of Cincinnati College of Medicine, 1911; aged 78; died September 19; member of the Ohio State Medical Association, the American Medical Association, American Psychiatric Association, and the American Geriatrics Society; diplomate of the American Board of Psychiatry and Neurology. A practitioner in the Dayton area for some 57 years, Dr. Braunlin was associated for many years with the Dartmouth Hospital of that city. In 1937 he was president of the Montgomery County Medical Society. Surviving are his widow, three sons, and four daughters.

Donald Wasson Briceland, M. D., Rimersburg, Pa.; Western Reserve University School of Medicine, 1934; aged 60; died May 3 as the result of a traffic accident. Records indicate that Dr. Briceland served most of his professional career in Pennsylvania.

Melvin Brody, M. D., Cleveland; St. Louis University School of Medicine, 1936; aged 57; died August 16; member of the Ohio State Medical Association, the American Medical Association, American Academy of Dermatology, and the American Academy of Facial Plastic and Reconstruction Surgery; diplomate of the American Board of Dermatology. Dr. Brody's early practice was centered in Canton. During World War II he served in the Army Medical Corps, and after the war moved his practice to Cleveland. Survivors are his widow, a son, a daughter, and his parents.

Jerome Lawrence Burke, M. D., Cleveland; University of Louisville School of Medicine, 1943; aged 49; died September 11; member of the Ohio State Medical Association and the American Medical Association. Dr. Burke's professional career in the Cleveland area extended over about 22 years. He was a native of Illinois and final rites were held from the Catholic Church in Pekin, Illinois. Among survivors are his widow, three sons, three daughters, and two brothers.

Clyde Withrop Crane, M. D., Elk City, Oklahoma; Ohio Medical University, Columbus, 1906; aged 89; died May 12; veteran of World War I. Records indicate that Dr. Crane practiced many years ago in Ohio — in Columbus and in Maynard. He left the state around the early 1930's.

Myrtle Collins Dineen, M. D., Kent; University of Michigan Medical School, 1941; aged 51; died September 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Dineen moved to Kent in 1948, and was associated there with the Kent State University Health

Center as well as engaging in private practice. She was also physician for the local school system. She is survived by two daughters, a son, her mother, and a sister.

Arthur Lawrence Dippel, M. D., Cleveland; Western Reserve University School of Medicine, 1916; aged 78; died September 2; member of the Ohio State Medical Association and recent member of the American Medical Association. Dr. Dippel's professional career extended over more than 50 years in the Cleveland area. He was a veteran of World War I, having served in the Army Medical Corps during the war period. Among survivors are his widow, a son, and a brother.

Hudson DeMott Fowler, M. D., Euclid; Cleveland-Pulte Medical College, 1903; aged 96; died September 15; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons and the International College of Surgeons. For many years Dr. Fowler practiced in the Collinwood area of Cleveland, and was one of the founders of the Euclid-Glenville Hospital, now Euclid General Hospital. He was a member of the Masonic Lodge and the Congregational Church. Surviving are a daughter and a son, Dr. Hudson D. Fowler II, also of Cleveland.

Jack Hertzman, M. D., Cincinnati; University of Cincinnati College of Medicine, 1932; aged 60; died September 20; member of the Ohio State Medical Association, the American Medical Association, American Psychiatric Association, American Academy of Child Psychiatry, and the American Physicians Fellowship; diplomate of the American Board of Psychiatry and Neurology. A practicing physician for many years in Cincinnati, Dr. Hertzman specialized in psychiatry with emphasis on child psychiatry.

John Walter Houk, M. D., Roanoke, Va.; Western Reserve University School of Medicine, 1929; aged 63; died September 15; former member of the Ohio State Medical Association and the American Medical Association. Dr. Houk moved to Virginia in 1964 after a long career in Cleveland. He was medical director for many years for the Nickel Plate Railroad and later for the Norfolk and Western Railway Company. Survivors include his widow, three daughters, two sons, and a brother.

Julian Kadobianski, M. D., Gallipolis; medical degree from the university in Karkow, Poland; aged 66; died September 2. A native of Austria, Dr. Kadobianski practiced in Poland before coming to this country some time before 1950. He had been on the staff of the Gallipolis State Institute since December of 1963. A brother survives.

Harold W. Lear, M. D., Coshocton; Eclectic Medical College, Cincinnati, 1924; aged 69; died September 19; member of the Ohio State Medical Association and the American Medical Association; former secretary-treasurer of the Coshocton County Medical Society. A native of Coshocton County, Dr. Lear returned there to practice shortly after completing his medical training. He was a veteran of World War I, a member of the American Legion, former president of the Rotary Club, member of the Methodist Church, and former city councilman. Among survivors are his widow, two sons, and a sister.

George Arthur Poe, M. D., South Mountain, Pa.; Ohio State University College of Medicine, 1918; aged 75; died September 8; former member of the Ohio State Medical Association; Fellow of the American College of Chest Physicians. A former practitioner in Port Clinton and coroner of Ottawa County, Dr. Poe moved to Pennsylvania about 1951. He is survived by his widow, a daughter, and two sisters.

Reinhold V. Rankis, M. D., Lisbon; Faculty of Medicine, Christian-Albrechts University, Kiel, Germany, 1950; aged 47; died September 18; member of the Ohio State Medical Association and the American Medical Association. A native of Latvia, Dr. Rankis came to this country in 1951. He moved to Lisbon in February, 1966, after being on the staff of Roose-



velt Hospital, Metuchen, N. J. His widow, two sons, and three sisters survive.

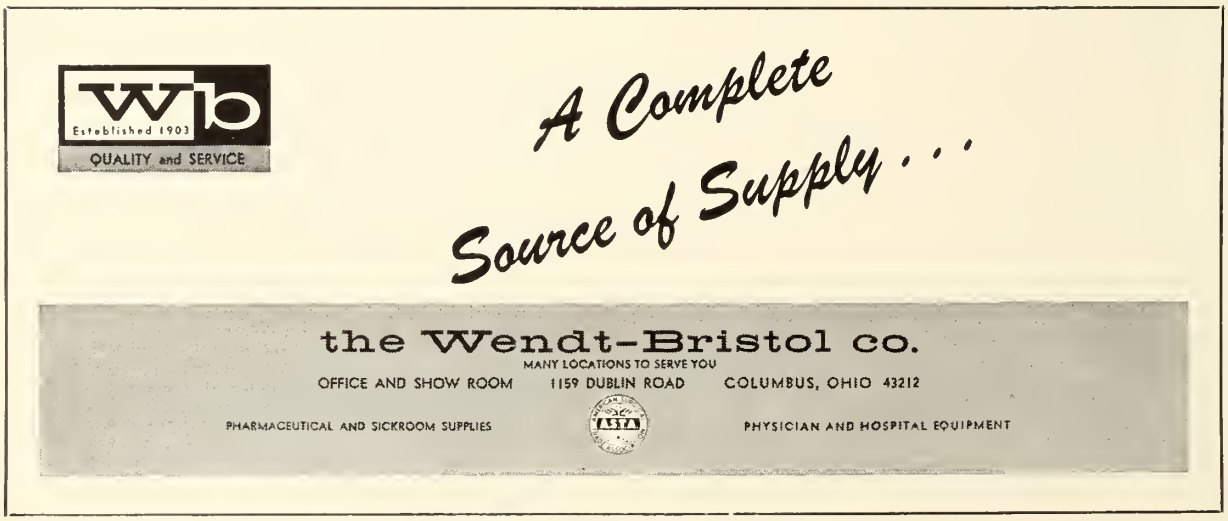
Wilbur Vernon Stinson, M. D., Dayton; University of Cincinnati College of Medicine, 1941; aged 54; died September 24; member of the Ohio State Medical Association, the American Medical Association, the American Academy of General Practice, American Society of Clinical Hypnosis, and the American Geriatrics Society. Dr. Stinson began his practice in Dayton after serving in the Army Medical Corps during World War II. His widow and his mother survive.

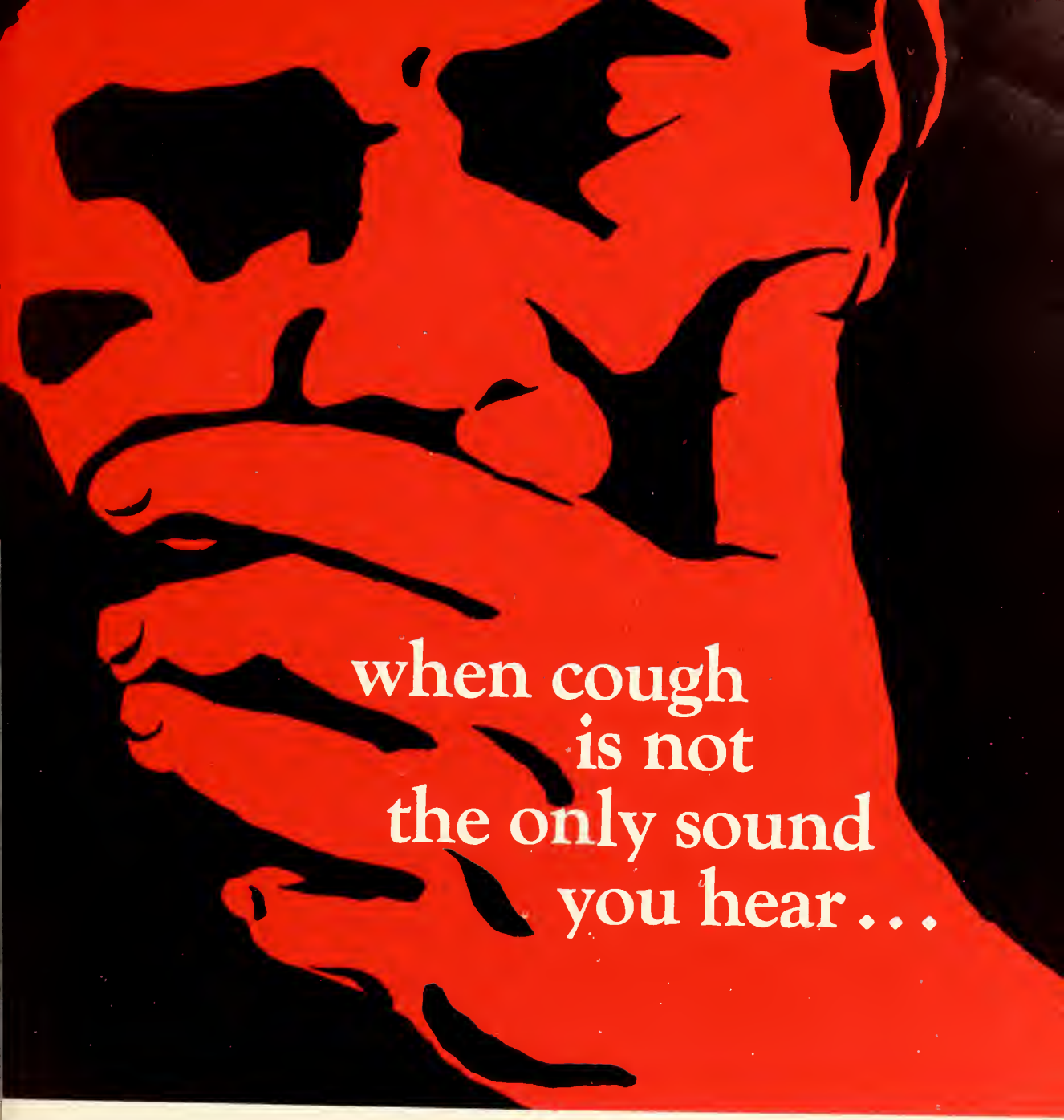
Paul P. Superfisky, M. D., Maple Heights; Marquette University School of Medicine, 1943; aged 50; died August 16; member of the Ohio State Medical Association, the American Medical Association, American Society of Abdominal Surgeons, and the American Geriatrics Society. Dr. Superfisky served most of his professional career in the Maple Heights area where he was a general surgeon. During World War II he served with the 86th Evacuation Hospital unit.

John W. Tarnapowicz, M. D., Hollywood, Florida; University of Pittsburgh School of Medicine, 1924; aged 72; died August 27; former member of the Ohio State Medical Association and the American Medical Association. Dr. Tarnapowicz began his practice in Youngstown after completing an internship in Cleveland. His practice extended over about 38 years. Brothers and sisters survive.

Herbert F. Van Epps, M. D., Dover; University of Rochester School of Medicine, 1931; aged 63; died September 10; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Van Epps opened a practice in New Philadelphia in 1936 and moved two years later to Dover where he had been in general practice since. Active in community affairs, he was a member of the Masonic Lodge, the Eagles Lodge, a director of the Kiwanis Club and a member of the Methodist Church. During World War II he served in the Army Medical Corps in France and attained the rank of major. His widow who survives is a past president of the Woman's Auxiliary to OSMA. Other survivors are a daughter and two sons, Dr. Keith C., of Detroit, and Kenneth, a medical student at the University of Tennessee.

Russell Ross Williams, M. D., Omaha, Nebraska; Ohio State University College of Medicine, 1943; aged 49; died June 1. Records indicate that Dr. Williams had been in practice in Omaha for a number of years. He was a diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons.





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The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

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For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining: enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

327-8

Activities of County Societies...

ALLEN

Dr. W. V. Parent was honored at the September meeting of the Academy of Medicine of Lima and Allen County, when he was presented the 50-Year Award of the Ohio State Medical Association for dedicated and distinguished service in the medical profession. The award was presented by Dr. Dwight L. Becker, OSMA Third District Councilor.

BELMONT

The Belmont County Medical Society and the Auxiliary met for dinner at the Belmont Hills Country Club on September 19.

A medical program was held in the late afternoon. Speaker was Dr. Dan W. Elliott, chief of the Division of Surgery, West Pennsylvania Hospital, Pittsburgh, whose subject was "Chronic Pancreatitis and the Diagnosis of Upper Abdominal Pain."

HAMILTON

For its November 19 meeting, the Academy of Medicine of Cincinnati has scheduled a panel discussion on the topic "Hallucinogenic Drugs—A Local and National Problem." This is a joint meeting with the Cincinnati Society of Neurology and Psychiatry.

Moderator of the panel is Dr. Daniel X. Freedman, professor and chairman, Department of Psychiatry, University of Chicago. Two panelists are Mr. Otto G. Heinecke, director of the Bureau of Drug Abuse Control; and Dr. Richard E. Bibb, assistant professor and associate director, Central Psychiatric Clinic of Cincinnati.

LORAIN

Members of the Board of Supervisors of Lorain County Medical Foundation, together with the students who received scholarships from the Foundation for the 1968-1969 school year, were guests of Lorain County Medical Society on September 10, at the Aquamarine Country Club in Avon Lake. Wives of physicians and Board members were also present for this first fall meeting of the Medical Society. This year, the Medical Foundation distributed $2500 from its Scholarship Fund to 11 area students—one in medicine, eight in nursing, one in speech and hearing therapy, and one in practical nursing. These were chosen from 47 applications received, and of the 11 successful students, six were renewals to 1967 recipients.

An innovation at this year's Recognition Dinner was the introduction of "Family Participation." Children of members (in the junior high, high, and college levels) were invited to attend, and 32 accepted the invitation. It was felt that this might prove to be a two-way stimulus in that physicians' families would be aware of a different aspect of the medical profession (other than late dinners, answering services, and canceled plans), and the scholarship students would be more comfortable among others of their own age group. But most important, it seemed a natural way to acknowledge that the Medical Foundation and the Medical Society are proud of these representatives of the younger generation.

Lorain County Medical Foundation, initially established several years ago with balance of funds from the Sabin Oral Sundays program, is operated

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.

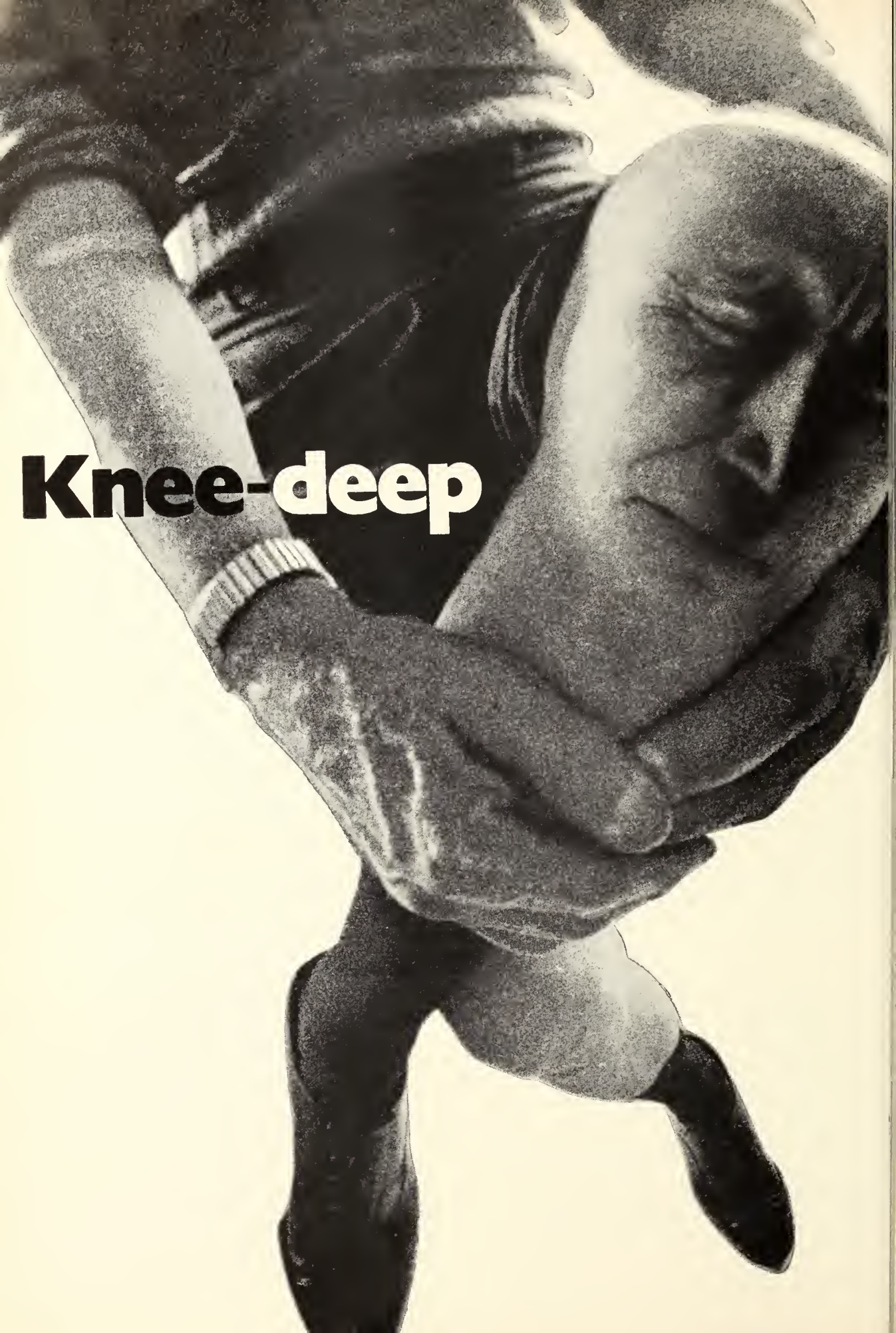


TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly: granulocytes decrease or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily; should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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For complete details, please see full Prescribing Information.

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as a trust with Lorain National Bank acting as trustee. Members of the community and physicians comprise the Board of Supervisors.

Carl M. Adams, president of Great Lakes Broadcasting Company, serves as Chairman of the Board, and Jack P. Mercer, M. D. as chairman of the Screening Committee. The Pharmaceutical Association is represented by Ed. Higgins, and Ralph Higgins, vice-president of the Lorain National Bank, acts as Treasurer. The Medical profession is represented by Drs. Henry E. Kleinhenz, Joseph A. Cicerella and Delbert L. Fischer, president of the Medical Society. Henry Schriver, well known area farmer, and Representative of the 75th District, is also a board member. Mr. Adams announced that two vacancies on the Board have recently been filled by the appointment of Jack M. Lyons, Plant Manager of Ford Motor Company in Lorain, and Otto B. Schoepfle, President and Publisher of the *Elyria Chronicle Telegram.*

Councilor of the 11th District, William R. Schultz, M. D., of Wooster, extended congratulations on behalf of Theodore M. Light, M.D., President of Ohio State Medical Association, and Mr. Carl M. Adams, in introducing Dr. Mercer to present the scholarship awards, gave a brief review of the Fund disbursements since the Foundation was established in 1963, and a resume of the students' progress.

During a brief business session preceding the Award ceremony, Paul J. Kopsch, M. D. of Lorain, delivered a Memorial Address in memory of Sidney R. Stone, M. D. of Wellington, which will become part of the permanent records of the Medical Society.

Scholarships Awarded in Lorain County



Students who received scholarships from the Lorain County Medical Foundation were guests of the Medical Society at the Country Club in Avon Lake. Principals in awards ceremonies are shown.

Front row, from left: Lynn M. Papp, Amherst; Dr. Jack P. Mercer, Lorain, chairman of the Screening Committee; Carl M. Adams, Chairman of the Board of Supervisors of Lorain County Medical Foundation; Maureen Gardner, North Ridgeville, Phyllis Yaschan, North Ridgeville; and Michael Lindamood, Lorain.

Back row, from left: Sandra Simpson, Avon Lake; Linda A. Moore, Elyria; Mrs. Albert McKitrick, Elyria; Stephanie Smith, Grafton; Rose M. Jenkin, Grafton; and Karen L. Novak, Lorain. Not present was Margaret Denna, Oberlin.

See accompanying report of Lorain County Medical Society Activities.

LUCAS

The Academy of Medicine of Toledo and Lucas County participated in the Postgraduate Lecture Series sponsored by the Northwestern Ohio Institute for Continuing Medical Education on September 11.

Dr. James F. Holland, chief of the leukemia service at Roswell Park Memorial Institute, Buffalo, N. Y., spoke on "The Principles and Practices of Cancer Chemotherapy. The series included cancer conferences at Wood County Memorial Hospital, Bowling Green, and Toledo Hospital.

Another September general program was the "Symposium of Venous Disease and Embolism," sponsored by the American College of Cardiology, and cosponsored by the Medical College of Ohio at Toledo. The program was held at the Commodore Perry Motor Inn, September 19-21.

The National Institutes of Health have awarded a $71,677 contract to the Academy of Medicine and its Northwestern Ohio Institute for Continuing Medical Education to develop a postgraduate educational program for physicians in Northwestern Ohio.

The program will be worked out by the Academy in conjunction with the new College of Medicine of Ohio at Toledo and with the Regional Program for Heart, Cancer, Stroke, and Related Diseases. Twenty counties comprise the area involved.

MAHONING

An article in the *Youngstown Vindicator* in mid-September reported that $10,850 had been given toward the proposed $30,000 medical school feasibility study. The feasibility study would lay the groundwork for the selection of Youngstown as the logical site for a medical school. Dr. Leonard P. Cassamo is the Mahoning County Medical Society's campaign chairman for the promotion of the study.

TRUMBULL

The Trumbull County Medical Society held its first meeting of the fall season on September 18 at the Trumbull Country Club, Warren, where dinner was served. It was a joint meeting with the Auxiliary.

A seminar on renal diseases for nurses and allied professions is being sponsored by the Pennsylvania Nurses Association at Chatham Center, Pittsburgh, October 27-29.

Employees of the Cambridge State Hospital and guests met for dinner and a program at the Berwick Hotel to honor Dr. Arthur T. Hopwood, who retired as superintendent of the hospital after 37 years of state service. Dr. James K. Gibson, former staff physician, has been named superintendent to succeed him.

Student Expresses Appreciation For Preceptorship Experience

The OSMA Committee on Rural Health offers one and two-week preceptorships in Ohio for junior students from medical schools in the state. Each student lives with the preceptor (a physician in general practice in a rural area, village, or smaller city) and his family. He accompanies the preceptor for the duration of the visit—to the office, hospital, medical society meetings, civic meetings, social events, on house calls, etc.

The following letter was received from a student in the College of Medicine, Ohio State University, following his one-week preceptorship with John R. Polsley, M. D., of North Lewisburg.

Benjamin Franklin Hospital
1755 Alum Creek Drive
Columbus, Ohio 43207
October 7, 1968

Committee on Rural Health
Ohio State Medical Association
Columbus, Ohio

Gentlemen:

I would like to thank you for giving me the opportunity of participating in your preceptorship program with Dr. John Polsley of North Lewisburg, Ohio. The week I was privileged to spend with this fine family physician was both enjoyable and extremely informative. I was shown in a favorable fashion the roles of the general practitioner which included (quoting a recent journal), "those of a personal, family, and community doctor; of protector of his patients from wrong or unnecessary hospitalization, protector of hospitals from the wrong types of cases, and protector of the community by saving money; of coordinator of all available medical and social services; and of manipulator of the patient's personal, social, and medical environments, whether in the family, at work, or elsewhere."

If Ohio does not gain a family physician (with the above ideals) as a result of my preceptorship, no one can blame the OSMA or Dr. John Polsley! Again, I thank you for this valuable experience.

Gratefully yours,
(Signed) R. Sheldon Jones

The Heart Association of Southwestern Ohio presented the sixth annual Frank Princi Memorial Heart Lecture on September 30. Speaker for the occasion was Christiaan N. Barnard, M. D., Groote-Schuur Hospital, Cape Town, South Africa, who discussed "Heart Transplants."

Woman's Auxiliary Highlights . . .

By MRS. ROBERT E. PUMPHREY, Chairman, Publicity Committee

3055 Big Hill Road, Dayton 45419

November 1968 Ohio Auxiliary Month . . . Letter from Auxiliary President . . . Famous Native Son of Darke County Makes Personal Appearance in Dayton and Captivates Audience . . . Cleveland Chrysanthemum Ball . . . Report on Ohio Fall Conferences.

DID YOU KNOW THAT there are 90,000 National Auxiliary members and nearly 5,600 in 53 Auxiliaries in Ohio? Many are planning special events for the month of November.

Letter from Auxiliary President

The following letter from Mrs. Malachi Sloan, president of the Woman's Auxiliary to the Ohio State Medical Association, covering the meeting of presidents and presidents-elect, held in the Drake Hotel in Chicago on September 30, spotlights Dr. Dwight L. Wilbur, president of the American Medical Association, and Shirley Temple Black.

Dear Audrey:

Greetings from Chicago! Yes, it is windy but quite warm. The annual Conference of Presidents and Presidents-Elect of the Woman's Auxiliary to the American Medical Association has been in session since Sunday, September 30. Would you believe that every state in the union including Alaska and Hawaii is represented here? Mrs. S. L. Meltzer, president-elect, and I are representing Ohio. We have heard Dr. Dwight L. Wilbur, president of AMA, and been briefed on everything from the characteristics of the men we married to the newest research in genetics (the latter supported by our own AMA-ERF contributions).

It was a thrill to hear the youthful and dedicated Dr. William B. Walsh of Project Hope fame. His first-hand report of this great ship of mercy made me wish every doctor's family could contribute time and money and material to Hope. Maybe we can do more about it through our International Health committees.

The most exciting part of the meeting was chatting with Shirley Temple Black. Imagine that dear little girl, now a lovely and gracious woman of forty who had a message we couldn't afford to miss. AMPAC entertained us at the Drake Hotel and the highlight of the evening was hearing about the exciting and sad events in Czechoslovakia last summer. You remember that she was in that country at the time Russia made her move. Being a fine actress and an able speaker, against a stirring musical background, she interpreted a song, recorded by a Czech Rock-and-Roll group, if you please, about the last few moments of freedom for that country. She turned it all about and made us face up to the fact that we have a few freedoms of our own to protect on November 5. We were delighted by this smiling woman who moved among us as though she'd known us always and more than that thought we were rather nice folks.

Ohio's own Ludel Sauvageot (Mrs. J. Paul Sauvageot of Akron) did the usual fine job of leading sessions designed to help us streamline reports. Aren't we fortunate to have her at work in our auxiliary? She had won the admiration and respect of all the national auxiliary leaders.

We are hurrying off to a Speech Seminar sponsored

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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415 Towerview Rd., Dayton 45429

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2280 West Wayne St., Lima 45805

by the AMA. This training will help us put across our points for the Woman's Auxiliary to the American Medical Association. Hope it boosts our membership in Ohio.

See you soon,

Jane

Lowell Thomas Launches Meeting Into Adventurous Mood

Lowell Thomas, a quiet, handsome man — world renowned explorer and news broadcaster, son of a doctor and born in Darke County — as guest speaker for the September 30 combined meeting of the Montgomery County Medical Society and the Woman's Auxiliary, took his captivated audience into lands of romance and forbidden cities.

The meeting was held in the ballroom of Kennedy Union at the University of Dayton. Dr. Peter A. Granson, president, Montgomery County Medical Society, presided and introduced the speaker. Mrs. Richard Krumholz and Mrs. Douglas Shanahan were chairmen for the dinner and the champagne reception later and did a wonderful thing of tying in the colors of the huge gold and orange fresh flower arrangement at the speaker's table, made by Colonial Flowers, with the orange and yellow draperies of the Kennedy Union Ballroom.

Dr. Theodore Light, President Ohio State Medical Association, and Mrs. Light—who was dressed in electric blue wool—were seated to the right of the speaker at the head table. Promptly at 6:45 p.m., at the podium, the newscaster went on the air for his daily news.

A Perilous Journey

Leading his listeners into fabulous realms of undreamed adventure following the dinner, Lowell Thomas told how, after World War II, through much innovation he had obtained permission for him and his son to take a caravan through the Himalayan Mountains into the forbidden city of Tibet. Adventurer that he was, and is—he still loves to ski—on the journey home he insisted on riding a horse that he had been advised was unbroken to saddle and highly spirited. It took five men to hold the animal while the rider mounted. Everything went well until, in an unguarded moment, after dismounting to collect and pocket some unusual looking stones that lay by the wayside, Thomas tried to remount his horse without help. The stallion turned swiftly, whirled—the speaker said, "I can see the look in that horse's eye to this day,"—and threw him down the side of a deep canyon.

Later it was discovered that the explorer's hip had been broken in eight places. He had to ride for 20 days in excruciating pain—no doctor or other American person had gained permission to enter Tibet with Thomas and his son. Attempts to rescue him by helicopter in that area at that time were impossible. (Unlike that experience, Mrs. Karl Ritter, retiring president of WA-AMA, actually did reach a meeting by helicopter.) It was ascertained that the helicopter closest to the Lowell Thomas caravan was located in the Philippine Islands and the caravan itself was traveling above the ceiling safe for helicopters. Nehru of India sent help on horseback.

In Gratitude

Lowell Thomas gives his son, Lowell, Jr., who now broadcasts from Alaska, the credit for saving his life on that perilous trip down through the Himalayas to a doctor and a hospital. In gratitude, the father turned over to the son the privilege of henceforth making the family public appearance speeches. Lowell's Dayton appearance was a rarity. From all reports there has been no more entertaining evening than this in the history of Montgomery County Medical meetings.

Looking at the straight, slim, handsome figure of a man, attired in a soft blue, well cut suit, who has helped to make history; listening to his clear, dramatic words delivered in a conversational tone and hearing him tell of how he loves to ski, it was hard to imagine that he could be any older than any of those to whom he spoke.

Mrs. Ritter Featured Speaker

At a September dessert luncheon of the Woman's Auxiliary to the Lima and Allen County Academy of Medicine held at the home of Mrs. Charles Burns, Mrs. Karl Ritter, retiring President of the Auxiliary to the American Medical Association, related on her experiences as president of that body and gave a thrilling account of how national meetings tick. Once she had to reach a meeting by helicopter. Mrs. Ritter, was also a winner in the Allen County "Bridge-A-Rama," proceeds from which will go to the scholarship fund.

Recognition was given to Mrs. William Noble for her commendable participation in the Auxiliary's current venereal disease project.

Scioto County Reports

District Director 9, Mrs. Armin A. Melior, reports that a district meeting was held October 17 to honor the immediate past president of the national auxiliary, Mrs. Karl Ritter; state president, Mrs. Malachi Sloan; and president-elect, Mrs. S. L. Meltzer.

At the initial fall meeting of the Woman's Auxiliary to Scioto County Medical Society, John Cummins, of the Ohio Department of Health, was speaker. As a representative of the Ohio Comprehensive Health Planning Program, Cummins stressed the need for interest and action to enable Scioto

County to qualify for federal funds under health planning.

Mrs. Jack MacDonald announced that a fifth series of baby sitting classes for junior and senior high school girls is being sponsored. Mrs. Ralph Herms is chairman.

Chrysanthemum Ball Americana

Mrs. William Mast, president, Cuyahoga County Auxiliary, says that this year's traditional "Chrysanthemum Ball, is scheduled on November 2 at the Sheraton-Cleveland Hotel. Mrs. Walter Sellars and Mrs. William Huffman are co-chairmen. The ball theme is a patriotic red, white, and blue theme. The occasion is formal and by invitation, with dancing and a program by "Up with People" choral group—a TV young peoples group of world-wide fame.

Table decorations for the ball featured Uncle Sam hats in red, white, and blue, filled with sparkler stars—one white star in each hat with the table number. Huge floor containers of real mums—red, white, and blue (blue and red dyed); tablecloths red and white plain colors—with the red and white alternating around the ballroom; the orchestral stage festooned with red and white bunting. Sounds like a real ultra glamorous affair!

Dr. and Mrs. Mast left in October for a trip to Japan and Hong Kong, sponsored by the Cleveland Medical Society. Bon "air"!

Erie County participates in hearing testing programs in Sandusky Public Schools. Members met on October 7 for a training session. Health Careers Programs are being arranged in many counties.

A **Lucas County** luncheon meeting featured a speaker on "Citizens Helping Eliminate Crime" (CHEC). On October 14 members of Woman's Auxiliary to the Lucas County Academy of Medicine heard Art Edgerton speak on the vital problem of what can be done to help solve crime in our cities. Edgerton, sightless since birth, has a B.A. degree in sociology and attends crime seminars in Ann Arbor. He helped organize CHEC. Auxiliary president is Mrs. Daniel E. Wolff, chairmen of the day were Mrs. Eli Abramson and Mrs. Samuel Karr.

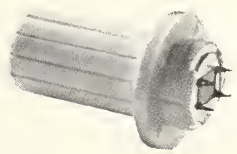
Lucas County Health Careers chairman, Mrs. Howard Madigan, extended an invitation to all Auxiliary members to attend the Annual Health Careers Recruitment Tea to be held October 30. Mrs. Jose Guerra was tea chairman.

(Thank you presidents and publicity chairmen for sending in news of your activities!)

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525 North Fourth Street

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1749 Cleveland Road

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WAYNE—John E. Loudenslager, President, 1736 Beall Avenue, Wooster 44691; Richard J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday monthly.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street. Suite 500, Columbus. Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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Editor of Medical Society Bulletin Discusses Physician Shortage

The following editorial comments appeared in a recent issue of the *Bulletin* of the Mahoning County Medical Society over the editor's signature. Although the discussion is localized in regard to establishment of a medical school, it touches on many points of paramount interest to all Ohio physicians.

EDITORIAL

"I'm not taking any new patients." How many times have you heard this lately? More important, how often do patients hear this when they call a physician for an appointment? There is every indication that it is too often. People are experiencing difficulty in finding a physician to care for them.

Are physicians becoming lazy? No, they are becoming more over-worked because there is a shortage of physicians.

The population of Mahoning County increased approximately 16.5% between 1950 and 1960, and this trend will probably continue. The membership of the Mahoning County Medical Society increased 8.4% from 1958 to 1968. So far this year, the membership has decreased by one.

This trend is not only true in Mahoning County, it is a nationwide problem. In addition, and perhaps more important, more and more physicians are specializing and fewer are remaining as primary physicians.

The problem, however, is not being ignored. Organized medicine, medical educators, government, industry, and labor are all working, (sometimes in harmony, sometimes at odds with each other) to find answers. Solutions will be found, and there will be more physicians. However, what do we do in Mahoning County in the interim? How do we attract our fair share (perhaps more than our fair share) of physicians to practice here?

Our Medical Society is taking steps to alleviate the shortage of medical manpower. We have the Mahoning County Medical Society Foundation to provide loans to medical students and encourage them to return to this area. We sponsor the scholarship dinner which indirectly encourages students toward a medical career. We also offer prizes for the best medical exhibits at the Fitch Tri-County Science Fair. We are participating vigorously in the race for the new medical school planned for Northeastern Ohio.

These activities are helpful, but they are not enough. We must find other ways.

The greatest source of physicians to practice in this area is the teaching programs of our hospitals. Of the 147 members on the active staff of Youngstown Hospital Association 90 or 61% have been on the house staff and received at least part of their training at Youngstown Hospital Association. We expect that the statistics at St. Elizabeth Hospital would be similar.

Our teaching programs are in trouble as are the programs of most community hospitals. The number of house staff positions far exceeds the supply, and the competition is exceedingly fierce. Some community hospitals, however, are making the grade, and none of them have more to offer than our hospitals in Youngstown.

There are young physicians who want post graduate training in community hospitals and there is evidence that medical educators are becoming more convinced that the community hospital should play a larger role in medical education, especially in the training of the primary physicians. Therefore the concept that our hospitals must be purely service hospitals without teaching programs is unthinkable.

We, as the Mahoning County Medical Society, must do everything in our power to encourage our hospitals to strive for good teaching programs. We should help in any way we can to recruit interns and residents. We should suggest that our hospitals procure full time people in all the major departments and at the same time work to insure that the generalist will continue to have a secure position in the academic atmosphere that results from a good teaching program.

Finally, we are in a good position to encourage cooperation between our two hospitals. Teaching talent and new equipment should be shared, and should be available to the house staffs of both hospitals.

If all of us work together through our society and through our own hospitals, there is no reason why we can't have teaching programs that are second to none. This will help greatly to increase the number of physicians in this area, and also help pave the way for the new medical school, if and when it arrives. —J. James Anderson, M. D., *Editor*

Dr. Charles M. Barrett, Cincinnati radiologist and educator, was voted an honorary life membership in the Hamilton County Unit, American Cancer Society, and was honored at the 32nd annual dinner meeting of the organization. Judge Otis R. Hess was honored in the same way.

Workshop on Medical Education Columbus, December 11

The Section on Medical Education of the Ohio State Medical Association is presenting its Third Annual Workshop on Wednesday, December 11. The theme is "State and Regional Planning—Your Boss or Your Servant."

Meeting place is Stouffer's University Inn, 3025 Olentangy River Road, Columbus, with the program starting at 9:55 a. m. Adjournment is scheduled for 2:30 p. m.

The program is especially for directors of medical education, educational committee chairmen, administrators, and other persons interested in medical education. Reservations at $5 per person (including luncheon and other expenses) should be made with Richard W. Juvancic, M. D., Secretary, Section on Medical Education, OSMA, 1350 East Market Street, Warren 44482.

The program includes the following features and speakers:

Welcome by Ralph Pickett, M. D., Section chairman.

Introduction of Speakers, Francis P. Kintz, M. D., program chairman.

Medical Education and Regional Medical Planning (RMP), Neil Andrews, M. D., program director, Ohio State RMP.

Medical Education and Comprehensive Health Planning, Sewall Milliken, coordinator, Comprehensive Health Planning, Ohio Department of Health.

Regional Comprehensive Planning and Administration, Barry Decker, M. D., program coordinator, Northeastern Ohio RMP.

Questions and Discussion—Resource People: Chester H. Allen, M. D., OSMA Committee on Government Medical Care Programs; James Sandman, Columbus Hospital Federation; C. Robert Tittle, M. D., program director, Northwestern Ohio RMP; and H. McBeath, M. D., program director, Ohio Valley RMP.

Continuing Education—Present and Future, William Pace, M. D., assistant dean and director of continuing education, OSU College of Medicine.

The Role of the Computer in Medical Education. Ralph Ingersoll, Ph. D., director, Division of Research and Services in Medical Education, OSU College of Medicine.

Questions and Discussion—Resource People: Warren G. Harding II, M. D., administrator and director of medical education, Grant Hospital, Columbus; Ralph E. Pickett, M. D., director of medical education, Licking County Memorial Hospital; and Lloyd R. Evans, M. D., assistant dean for curriculum, OSU College of Medicine.

OSMA Executive Secretary Chairs AMA Advisory Committee

Hart F. Page, Executive Secretary of the Ohio State Medical Association, has been named chairman of the Advisory Committee to the Director of the Communications Division, American Medical Association.

Now in his third year as a member of the Advisory Committee, Mr. Page was elected for a one-year term as chairman beginning in October. The committee is composed of medical society executives from California, Illinois, Kansas, Louisiana, Nebraska, New York, Ohio, Tennessee, and Utah.

Mr. Page's background in medical organization work includes extensive experience in the communications and public relations field. He is a graduate of Ohio State University with a bachelor of science degree in journalism.

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Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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The OHIO STATE MEDICAL Journal

Published By The Ohio State Medical Association

DISPLAY SHELVES

EMBER 1968
ME 64 ★ NUMBER 12

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Annual Roundup on Federal, State and Local Taxes for Physicians

A summary indicating deadlines to meet, forms to file, tax liabilities in various categories, etc.

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Selected Scientific and Clinical Articles, beginning on page 1351

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Cross Index for 1968 Journals . . . Pages 1422 - 1429



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He says "It's my stomach..."

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functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

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Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

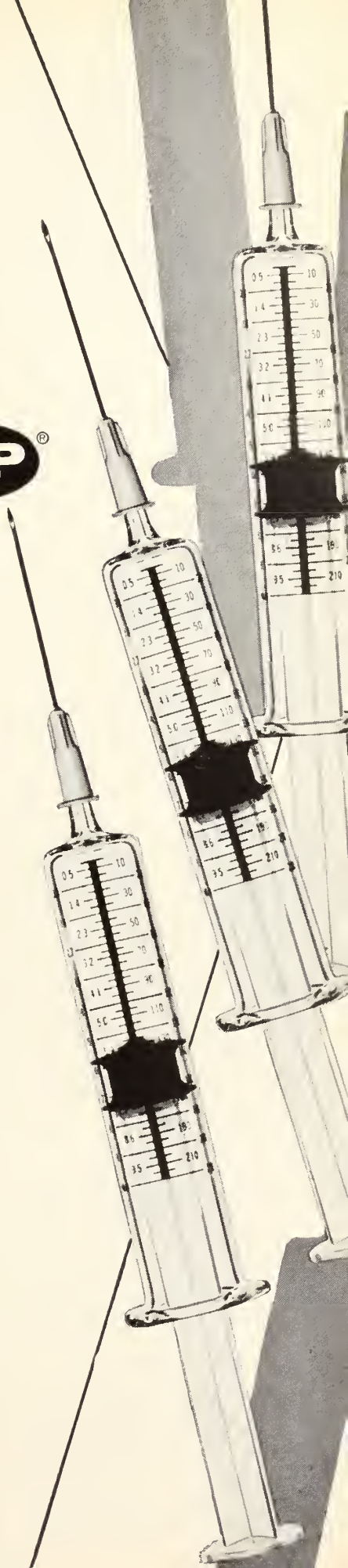
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The
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Journal

VOL. 64 DECEMBER, 1968 No. 12

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Address All Correspondence:
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Columbus, Ohio 43215

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Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

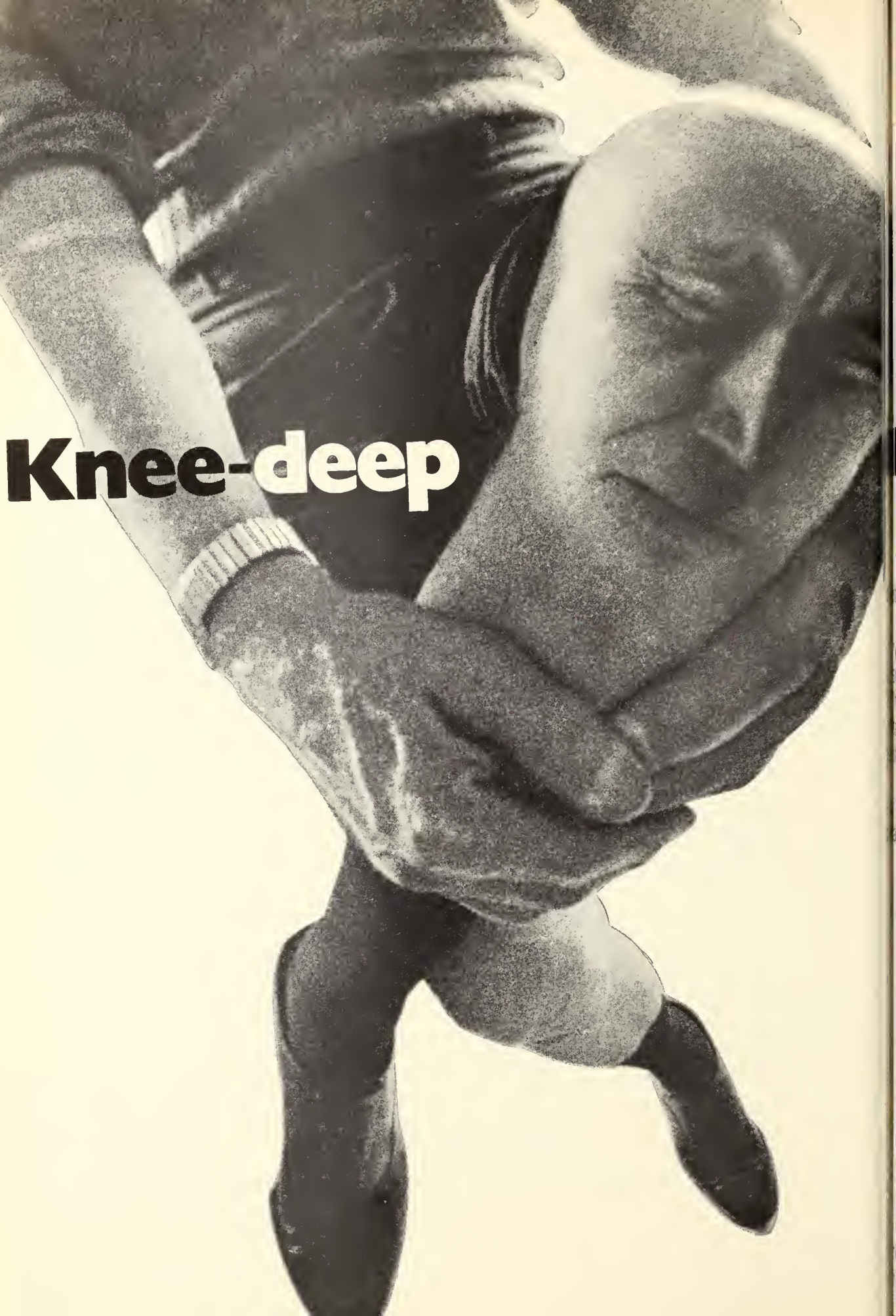
Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

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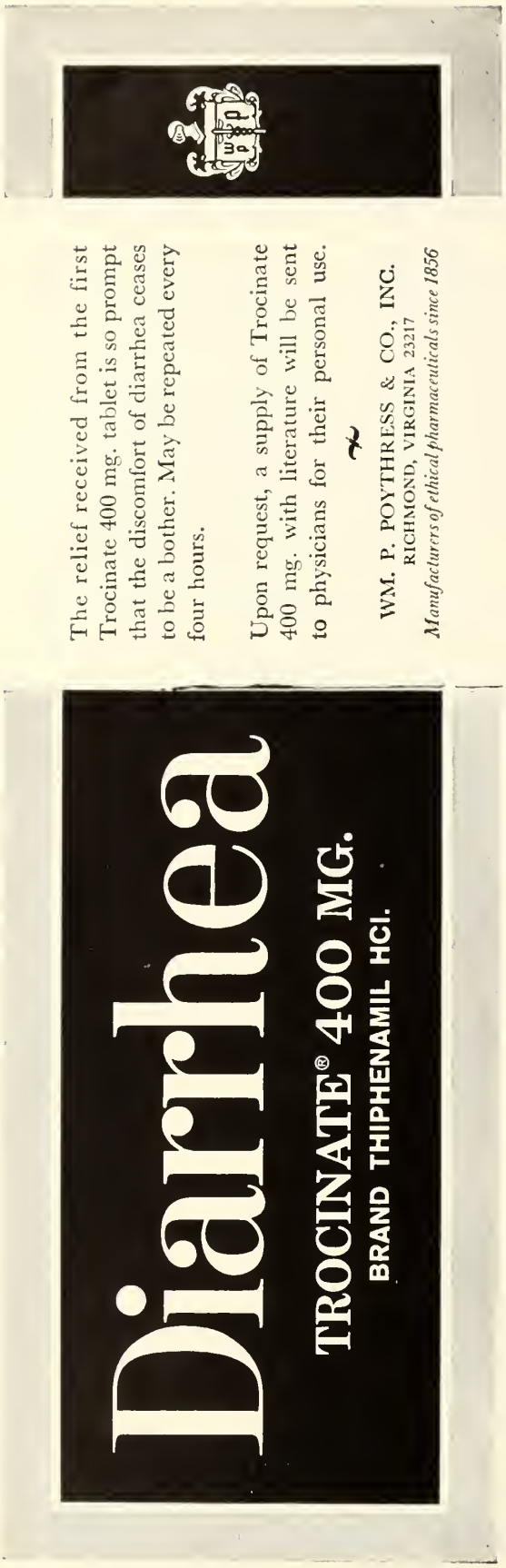
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Letter to the Editor

October 4, 1968

To the Editor
Ohio State Medical Journal
Columbus, Ohio

In their article, ECTOPIC PREGNANCY WITH INTRA-UTERINE DEVICE — A CASE REPORT, which appeared in the August 1968 issue, Dickey and Gall imply that the incidence of ectopic pregnancy in women using intra-uterine devices is considerably greater than in those women who are not using intra-uterine devices. The fact of the matter is, that a woman using an intra-uterine device has much less risk of developing a tubal pregnancy than does the woman who is not using a device. The intra-uterine device is highly effective in preventing ectopic pregnancies. However, it is even more effective in preventing intra-uterine pregnancies. Therefore, in those few cases where pregnancy does occur with an intra-uterine device in place, the *proportion* of ectopic pregnancies is quite high. For this reason, a clinician should always consider ectopic pregnancy "whenever a woman with an IUD develops acute abdominal pain in association with any of the common symptoms of pregnancy." At the same time, he should rest assured that he is preventing a great many ectopic pregnancies by using the intra-uterine device.

Sincerely yours,
(Signed) George C. Denniston, M.D.
Associate Medical Director
Planned Parenthood—World Population
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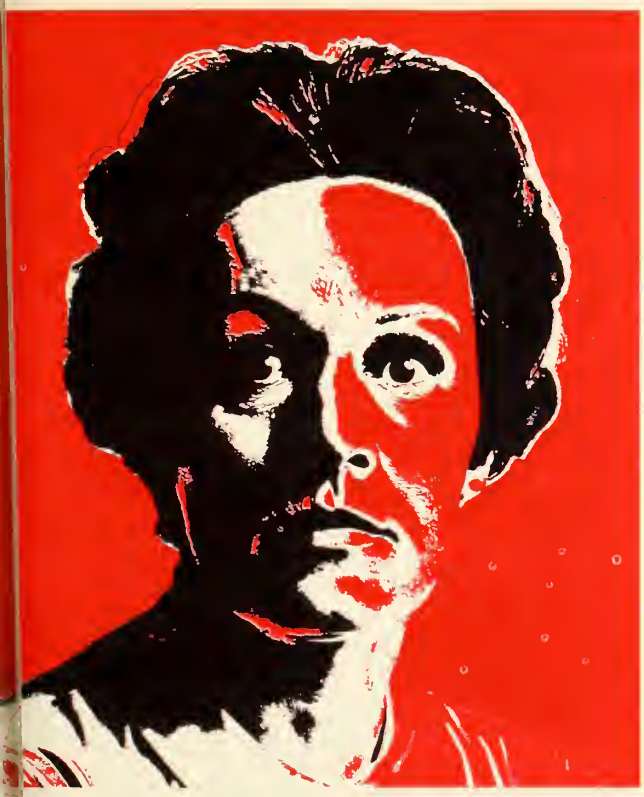
New Nursing Education Facility Dedicated in Cincinnati

The William Cooper Procter Hall, Cincinnati's new nursing education facility, was officially dedicated early in October. The four-story classroom, library, and continuation education center for the College of Nursing and Health of the University of Cincinnati is at St. Clair and Vine Streets, midway between the University of Cincinnati's Clifton campus and the Medical Center in which it is a major unit.

In the nursing center a continuation education program for 100 persons can be handled. The auditorium is one of a number of stations in the closed circuit television network of the Medical Center.

The building is named for William Cooper Procter, grandson of the co-founder of the Procter & Gamble Company. A gift from Miss Mary E. Johnston, niece of William Cooper Procter, enabled the college to start planning for the building. Other private gifts and a $1.6 million federal grant also financed the structure.

n the complex picture
f moderate to severe anxiety...



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Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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*anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

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in *Staphylococcus aureus* cultures,
as shown in
studies of
antibiotics.

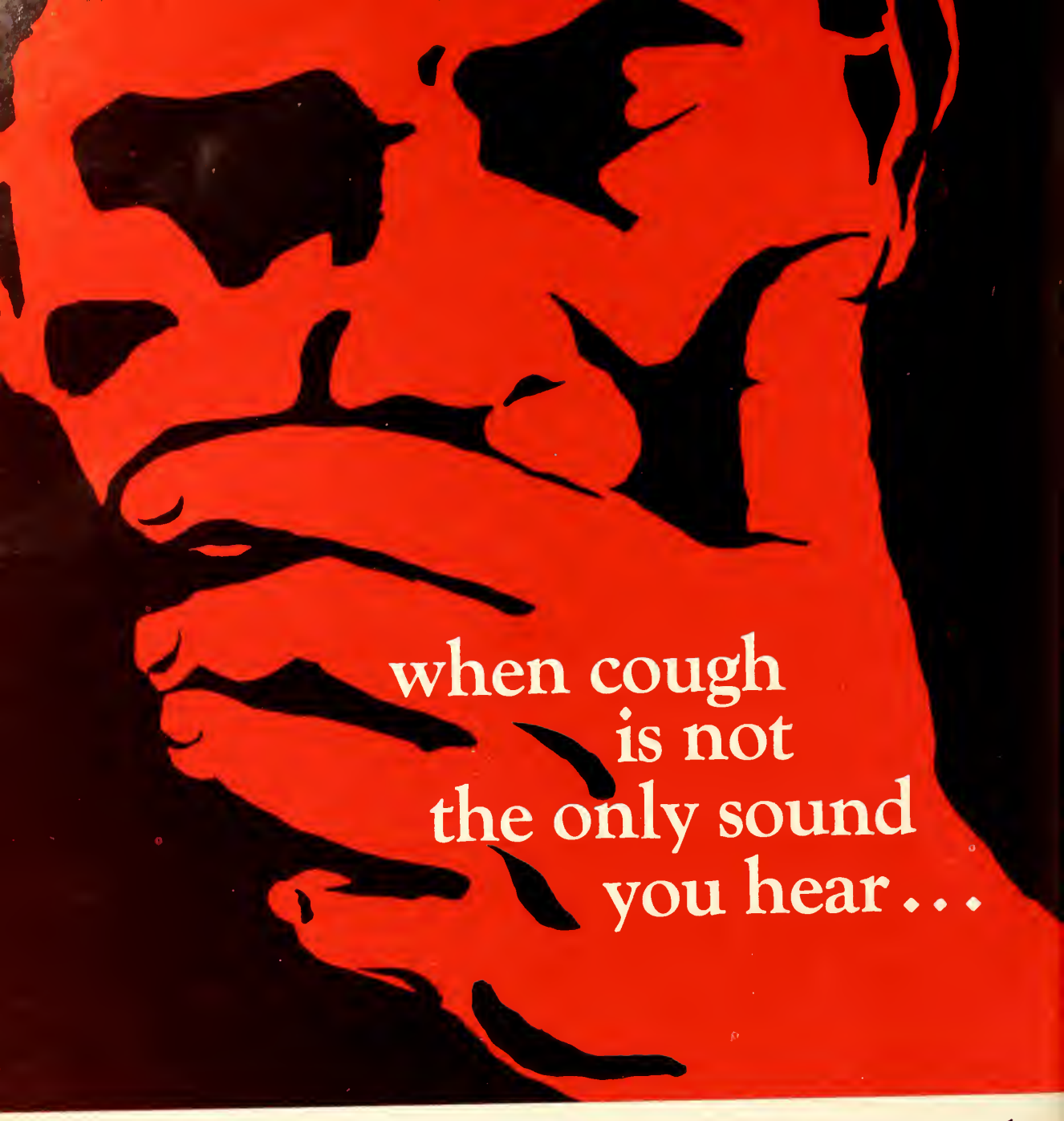
SUSCEPTIBILITY RESULTS[1,2,3]
Staphylococcus aureus

= OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1 Fowler, J. Ralph et al Clinical Medicine 70 547 (Mar.) 1963 2 Isenberg, Henry D Health Laboratory Science 1 185-256 (July Aug 1964 3 Isenberg, Henry D Health Laboratory Science 2 163 173 July 1965

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to this antibiotic and resistance
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Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

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What the Patient REALLY Wants In Hospital Accommodations

By WARREN G. HARDING II, M.D., Administrator, and GARY SILVERS, Associate Administrator,
Grant Hospital of Columbus, Ohio

THE RECENT THRUST by the Federal Government and by organized medicine to involve physicians in the planning and administration of health care[1,2] assumes several factors. The first is that practicing doctors are aware of the mechanism by which they can participate in this overall activity. A recent survey of 400 practitioners in a 36 county area in Ohio revealed that very few had a basic understanding of what is meant by area or regional planning.[3] The second assumption is that doctors are well informed about the operation of a hospital by virtue of attending their patients in the hospital on a daily basis. This latter facet is obviously erroneous if one takes the time to question the physician about specific items of hospital activities. The usual answer one receives is, "That is out of my line." If on the other hand a physician is to participate in the operation of a hospital, the major provider of health service, as a member of the Board of Trustees, he must have knowledge upon which to base his decisions. This information is not a part of his medical education in any curriculum of an American medical school.

The following study was undertaken to establish objective data from Grant Hospital of Columbus regarding the desires of 1,000 competent patients for type of accommodation. The polemic among planners, between architects, administrators, physicians and nurses has reflected personal bias, construction costs, aesthetics and patient comfort. The question of what the patient wants has not been clearly documented in this controversy.

Grant Hospital of Columbus is a community hospital of 438 beds. Private, semiprivate and three-bed wards are available. Approximately 20,000 patients are admitted annually. The survey covered 5 per cent of our annual admissions. The interviews were made on admission by our service representatives in the admitting department and on discharge by the nursing service department. The type of patient served is shown in Table 1.

The profile of the majority of patients in this study was female, under the age of 50, admitted for surgery, had been in the hospital sometime during the past ten years, and had semiprivate accommodations.

TABLE 1. *Type of Patients Served*

Sex			Age		
Male	352	35.2%	Under 50	645	64.5%
Female	603	60.3	50-65	207	20.7
Blank	45	4.5	Over 65	137	13.7
			Blank	11	1.1
Total (N)	1,000	100.0%	Total (N)	1,000	100.0%
Type of Service			**Previous Hospital Admission**		
Medical	196	19.6%			
Surgical	551	55.1	First Admission	206	20.6%
Obstetric	20	2.0	In hospital last year	229	22.9
EENT	221	22.1	Last 10 years	488	48.8
Blank	12	1.2	Blank	77	7.7
Total (N)	1,000	100.0%		1,000	100.0%

Type of Accommodation

Private	179	17.9%
Semiprivate	589	58.9
Ward	232	23.2
Total (N)	1,000	100.0%

The distribution by sex of three to two, with females predominating, tends to substantiate the commonly held opinion that women accept hospitalization more willingly than men. The admissions were four to one on a surgical service, though the hospital-bed population is only 55 per cent surgical. Sixty-five per cent were under 50 years of age. Although only 13.7 per cent were over 65, they constitute 25 per cent of our bed occupancy. The last two exceptions are a reflection on the length of hospital stay and must be carefully considered in the planning process. Almost 60 per cent of the patients were in semiprivate rooms. This reflects the room distribution at Grant Hospital. The fact that 72 per cent of the patients had a known previous hospital experience adds authenticity to the choices expressed.

The patients expressed the following choices on admission:

A. What type of accommodations do you prefer? (Table 2-A)

Private	203	20.3%
Semiprivate	754	75.4
Ward	41	4.1
Blank	2	.2
Total (N)	1,000	100.0%

B. If cost would be no object, would your choice change? (Table 2-B)

No	821	82.1%
Yes	177	17.7
Blank	2	.2
Total (N)	1,000	100.0%

C. For those patients (177) whose choice would change if cost would be no object, their choice would be: (Table 2-C)

Private	166	93.8%
Semiprivate	11	6.2
Total (N)	177	100.0%

What do these figures reveal? They indicate quite clearly that most of these patients preferred semiprivate rooms. There was very little desire for ward accommodations. In addition, cost is no major factor in the patient's choice of accommodations. However, for those patients whose choice would change if cost would be no object, the trend is strongly toward a private room. Age or sex did not affect the choice of this group.

Did the patient's feeling change after having been in the hospital for an average length of nine days? It is amazing that these patients' opinions had changed very little. Almost 83 per cent of the patients made the statement that they were happy with their accommodations. Only 174 patients expressed a desire for different accommodations should they require further admission to a hospital. Their desires are summarized below.

D. The distribution and preference of the 174 patients desiring a change in future admission was as shown in Table 2-D.

Of the 232 patients who were in wards, 101 or nearly 44 per cent of the total desired to change, primarily to semiprivate accommodations. On the other hand, only 23 patients in private accommodations of a total of 179, or 13 per cent, and 50 patients of a total of 589, or 8.5 per cent, in semiprivate accommodations desired to change. Of all the 174 patients who desired to change their accommodations in future admissions, 113 or more than 63 per cent desired semiprivate accommodations. These figures are substantially the same when the cost factor was eliminated. The age group between 50 and 65 showed a higher percentage desiring a change of type of room, with most of them expressing a desire for the semiprivate rooms.

The survey has shown that approximately 80 per cent of these patients were satisfied and happy with the so-called semiprivate accommodation. Those patients expressing a desire to change if cost would be no factor in their choice clearly indicated that the trend would be toward more private rooms. The influence of cost of construction, nursing service efficiency, building maintenance, communication between patient and medical or paramedical staff, visitors, interpersonal stimulation between patients, flexibility in use of rooms, and cross-infection control are, of course, other elements of importance in the determination of the type of room accommodation

TABLE 2-D. *Distribution and Preference of 174 Patients Desiring a Change in Future Admission*

Were in:		% Total Desiring Change	In Future Admissions, Desire To Be In Private	Semiprivate	Ward
Private	23	13.2%	0	22	1
Semiprivate	50	28.8	46	0	4
Ward	101	58.0	10	91	0
Total (N)	174	100.0%	56	113	5

that must be considered. However, insofar as the average patient in Grant Hospital is concerned,

1) he prefers semiprivate room accommodations;
2) if he is in ward accommodations, the likelihood of wanting to change in a future admission is more probable;
3) cost is generally no major factor;
4) neither is sex or age;
5) a ratio of 20 per cent private rooms and 80 per cent semiprivate rooms seems to be the ideal configuration in bed accommodation.

References

1. Proceedings, AMA House of Delegates, 1967 Annual Convention.
2. Policy Statements Regarding Government Medical Care Programs, *OSMJ*, May-June, 1967.
3. Harding, Warren G. II, and Herron, Clay, Physician Involvement in Areawide Planning—Fact or Fiction, *OSMJ* Aug. 1968.

Symposia Mark 150th Year of UC College of Medicine

As part of the University of Cincinnati Sesquicentennial celebration, the College of Medicine presents in 1969 two symposia on major medical issues.

On Wednesday, January 22, "Man and the Value of Life" will feature a discussion of the problems arising out of technological advances in medicine, such as organ transplantation, mechanical assistance of respiration, heart action, and artificial feeding; and longevity as aided and abetted by medical means.

Speakers include Dr. Jacques Barzun, university professor, Columbia University; Dr. Rene Dubos, professor, Rockefeller University; Dr. Michael E. DeBakey, vice-president for medical affairs, Baylor University College of Medicine; Judge David L. Bazelon, chief judge, U. S. Court of Appeals, Washington, D. C., and Bishop Roger W. Blanchard, Diocese of Southern Ohio.

The public is invited. For further information contact Dr. Charles D. Aring, director, University of Cincinnati Department of Neurology, Cincinnati General Hospital, Cincinnati 45229.

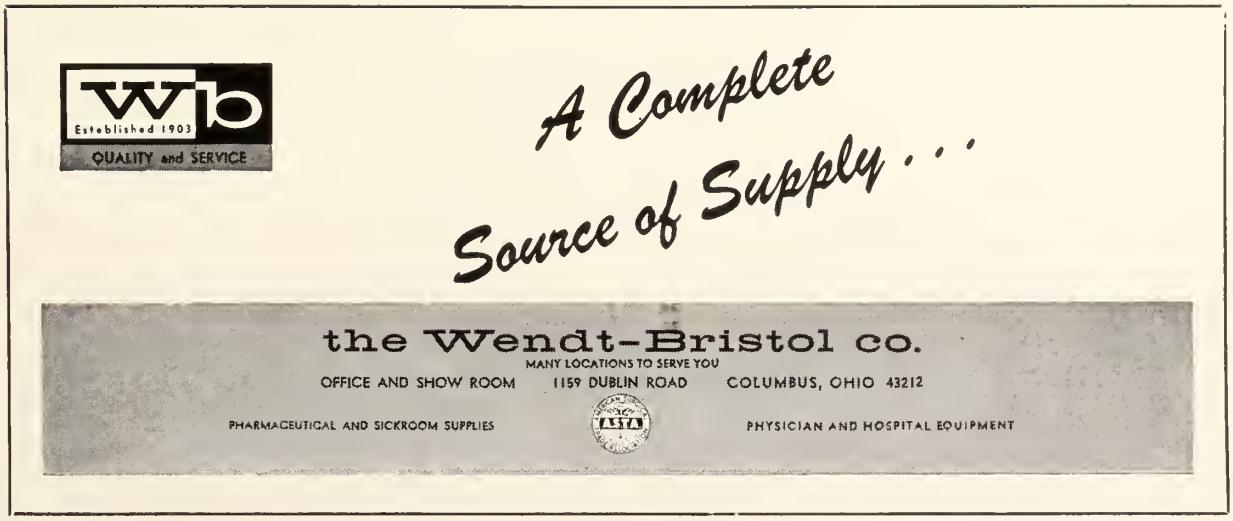
Revised Statement Is Available On Diet and Heart Disease

A revised statement on Diet and Heart Disease has been prepared by the American Heart Association for professional use of physicians, nutritionists, dietitians and nurses.

Because of increasingly strong evidence that dietary control may help to prevent or slow the progress of coronary heart disease, the Heart Association revised its statement issued in 1965 on diet and heart disease to conform with the latest supporting data.

In general the dietary recommendations involve a decrease in the intake of saturated fats and an increase in the intake of polyunsaturated fats; caloric intake adjusted to achieve and maintain proper weight and a substantial reduction of cholesterol in diet.

Copies of the revised statement may be obtained from the Ohio State Heart Association or from its chapters located in Akron, Columbus, Canton, Youngstown, Cleveland, Cincinnati, Dayton, and Toledo.



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Position Stand of The Ohio Psychiatric Association On Suggested Changes in the Abortion Laws of Ohio

By IRWIN N. PERR, M.D., J.D., Cleveland; BASIL D. ROMAN, M.D., Akron; and DAVID S. SCHWAB, M.D., Cincinnati*

THE OHIO PSYCHIATRIC ASSOCIATION has polled its members on present and suggested abortion laws for the State of Ohio. Based on the response to the questionnaire, the Council of the Ohio Psychiatric Association and the Ohio Psychiatric Association at large have recommended specific changes in current laws — changes which will be enumerated below.

The letter to each member psychiatrist stated, "The O. P. A. Legislative Committee on Abortion is interested in determining the position of each member in regard to Ohio's abortion laws. In our task of developing approaches to influence the legislature, we wish to more accurately reflect the attitudes of our membership. We would appreciate your checking each of the conditions below in which you feel the laws should be liberalized. We would welcome any additional comments you care to write."

The categories listed were:

1. The present laws concerning abortion are adequate.
2. Abortion should be legalized when there is a high probability of a physical or mental defect in the fetus.
3. Abortion should be legalized for cases of rape or incest.
4. Abortion should be legalized for statutory rape.
5. Abortion should be legalized when the mental health of the mother is threatened.
6. Abortion should be legalized when the general socioeconomic welfare of the mother and the family are threatened.
7. Abortion should be legal for any individual with an unwanted pregnancy.

Two hundred and twenty responses to the mail questionnaire (about 55 per cent of membership) were received. A few responses required some discretion in categorization but these were quite few and were classified according to the general tenor of the comments if such qualifications were made.

The results are tabulated below. The first group is that of members who feel that present laws are adequate. The responses beneath indicated that the law should be extended to allow for abortion in the situation listed.

Summary of Questionnaire Results
(220 responses)

		No.	*Pct.*
1.	Law is adequate	14	6.4
2.	High probability of physical or mental defect in the fetus	196	89.1
3.	Rape or incest	199	90.5
4.	Statutory rape	171	77.7
5.	Mental health of the mother is threatened	189	85.9
6.	General socioeconomic welfare of the mother and family is threatened	111	50.5
7.	Any unwanted pregnancy	72	32.7

The results were roughly similar to that of Crowley and Laidlaw,[1] who reported on a similar questionnaire sent to 13,000 members of the American Psychiatric Association (plus 800 to foreign members) with about 5,000 replies. The per cent in favor of change on conditions similar to numbers 2 through 5 were 86.3 to 91.7 per cent. A small group (165) of Canadian psychiatrists favored similar changes by percentages of 77.6 to 86.7; a somewhat smaller group (98) of other foreign psychiatrists (Europe, Latin America, Asia) favored similar changes by 69.4 to 79.6 per cent.

To summarize, only 6.4 per cent of Ohio psychiatrists polled felt that the present laws were adequate. Large majorities (77.7 to 90.5 per cent) favored permissible termination of pregnancy in situations where there is a high probability of physical or mental defect in the fetus, pregnancy as a result of rape, incest, or statutory rape, and when the mental health of the mother is threatened. A slight majority felt that socioeconomic factors should be a factor in such decisions, and about one third felt that there

*Dr. Perr is Chairman, and Drs. Roman and Schwab, members of the Committee on Abortion, Ohio Psychiatric Association. Communications may be directed to Dr. Perr, 2231 Taylor Road, Cleveland 44112.

should be no legal restrictions on unwanted pregnancies.

On February 13, 1968, the Council of the Ohio Psychiatric Association passed a resolution, recommending that the Ohio law be changed to incorporate the conditions listed in numbers 2 to 5 as ones which would allow for a therapeutic termination of pregnancy on medical recommendation. This resolution was adopted by a general meeting of the Ohio Psychiatric Association on February 14, 1968, by unanimous vote. Also adopted was a request that this study and recommendation be published in the *Ohio State Medical Journal* so the medical profession at large in Ohio would be informed of this position.

References

1. Crowley, R. M., and Laidlaw, R. W.: Psychiatric Opinion Regarding Abortion: Preliminary Report of a Survey, Am. J. Psychiat., 124:559-562 (Oct., 1967).

Ohio Institutions Receive Grants from Drug Manufacturer's Foundation

Total contributions by the Smith Kline & French Foundation to charitable, educational, scientific, and community purposes have passed the $10 million figure, it was revealed in the Foundation's 1967 annual report.

Contributions for 1967 were $909,791, third highest annual total since the Foundation, established by Smith Kline & French Laboratories of Philadelphia, began granting funds in 1953.

During its 15 years of operation, the Foundation has grown in breadth of interest as well as in volume of financial contributions. Its principal interest, however, remains medicine and the sciences related to medicine.

Some 16 medical colleges, other educational institutions, and hospitals in Ohio received grants from the foundation during the year.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during October. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Athens
John F. Kroner, Jr., Athens

Butler
Spencer F. August, Hamilton
Joseph H. Brandabur, Hamilton
William D. Langworthy, Middletown
Carlos M. Lara, Hamilton
Jesus M. Sotelo, Hamilton

Clark
Raymond N. Cooper, Springfield
Sylvan D. Eller, Medway

Cuyahoga
John Y. Kalucis, Cleveland
Charles Clifford York, Cleveland

Darke
Samuel M. Brubaker, Arcanum

Hamilton
James Dumont Wharton, Cincinnati

Lorain
Deogracias M. Abella, Lorain
Ronald A. Schwert, Vermilion

Lucas
Gregor K. Emmert, Toledo
Philip L. Kuebbeler, Toledo
Claro T. Tosino, Toledo
A. M. Vicente, Toledo
Richard J. Wiseley, Toledo

Mahoning
John H. O. Bleacher, Youngstown
Ikuo Maeda, Youngstown
Ronald M. Roth, Youngstown

Pickaway
Emily E. Lutz, Circleville

Summit
Frederic A. Helmer, Akron
Keith P. Kaufman, Akron
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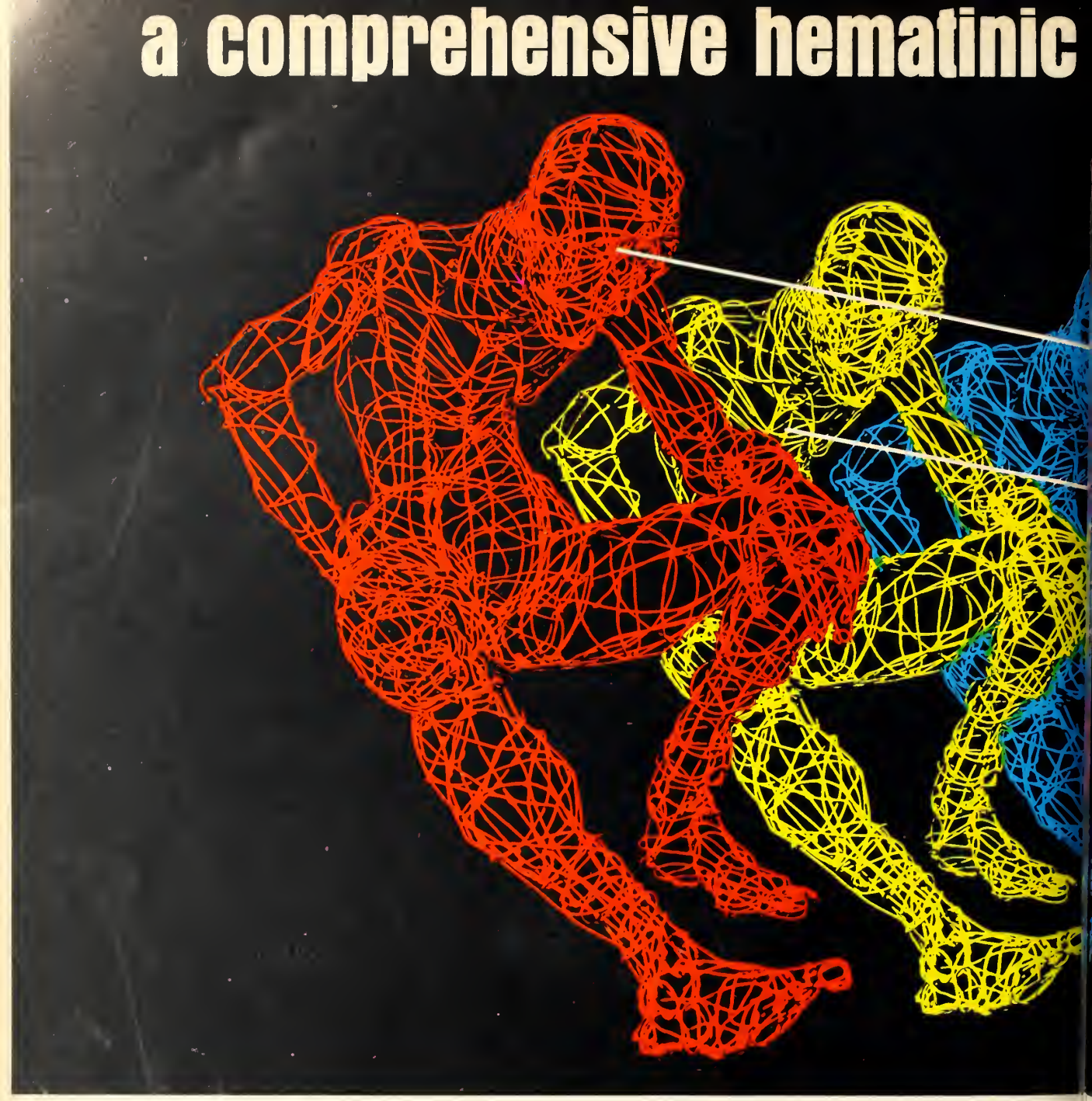
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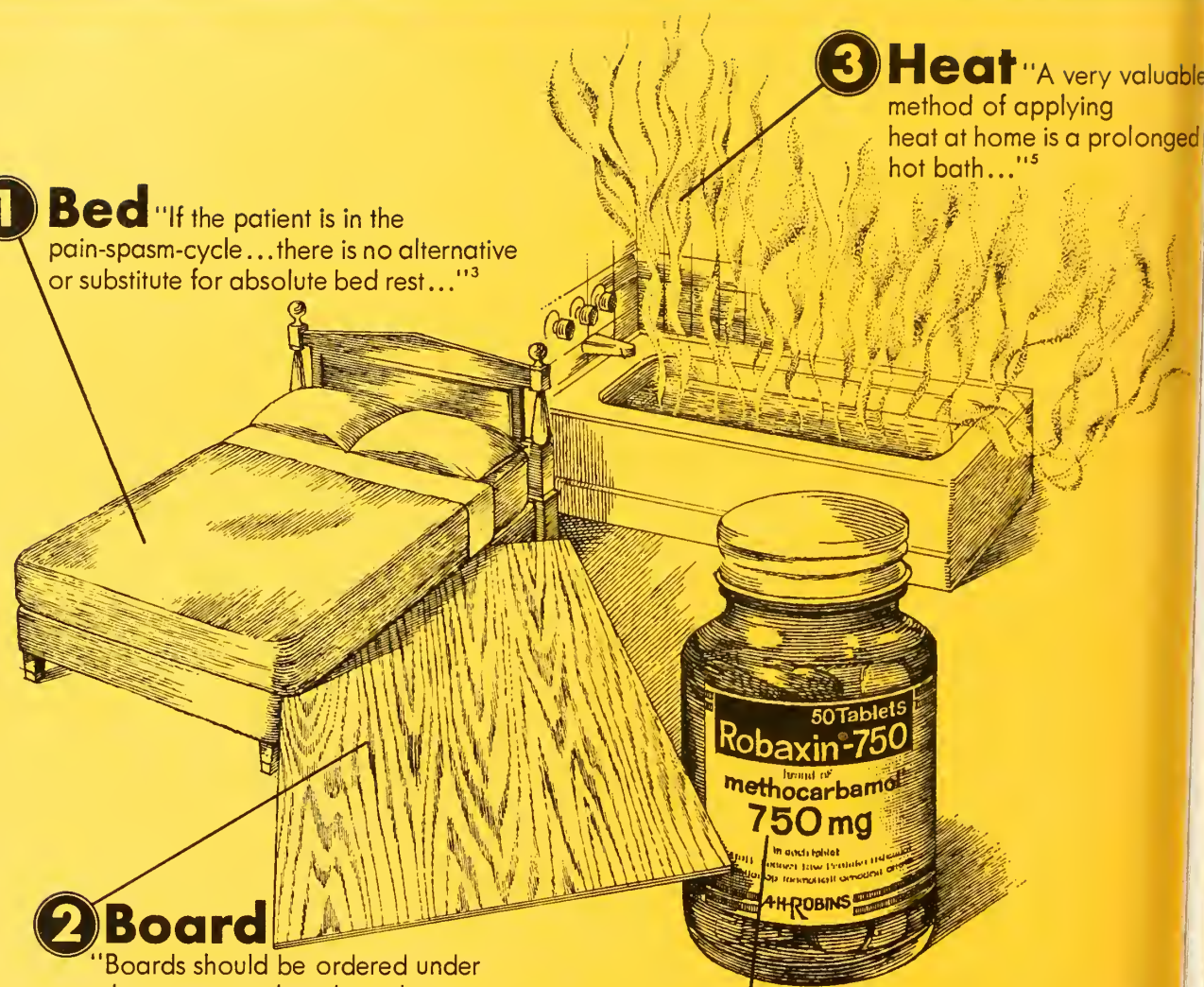
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VOL. 64 DECEMBER, 1968 NO. 12

Mediastinal Cysts and Tumors

CHARLES MARKS, M.D., SAMUEL O. FREEDLANDER, M.D.,
and ALBERT BENNETT, M.D.

MEDIASTINAL CYSTS AND TUMORS represent space-occupying masses which may be situated in the anterior, middle, or posterior mediastinum. The anterior mediastinal masses are generally retrosternal goiter, thymic neoplasms (both benign and malignant) tracheobronchial cysts, pleuropericardial cysts, dermoid cysts, and teratomata. The middle mediastinum is frequently involved in patients with bronchogenic carcinoma, lymphoma, or vascular abnormalities such as aortic aneurysms. The posterior mediastinum is mainly involved by neurogenic tumors and predominating among these are neurofibromas, although ganglioneuromata and neuroblastomata and occasionally a neuroepithelioma may be found.

Following is an analysis of 100 patients presenting with mediastinal masses at Mount Sinai Hospital of Cleveland and operated on over the past 20 years (Table 1). In 14 patients, the mediastinal masses were part of a lymphomatous process, viz, Hodgkins Disease, lymphosarcoma, and lymphoblastoma; in two patients the masses were mediastinal metastases consequent to malignant tumors elsewhere viz, pancreas and dysgerminoma of ovary; in 13 patients bronchogenic carcinoma led to presentation with major mediastinal involvement; and 70 patients presented with primary mediastinal tumors or cysts.

Mediastinal Cysts

(A) Development aberration of the primitive foregut results in several varieties of mediastinal cysts. The esophagus and respiratory tract have a common origin, arising from the primitive foregut, and the development of longitudinal bilateral septa leads to the formation of a ventral component which proceeds to form the trachea and its major bronchi and a dorsal component which forms the esophagus.

(1) **Bronchogenic Cysts:** These derive from the respiratory system and develop as a result of an abnormal branching of the tracheobronchial tree, being closely related pathogenetically to aberrant pulmonary tissue as well as to congenital intrapulmonary bronchial cysts,[4] which represents persistence of bronchial tree continuity. If the mass of developing cells separates from the main tracheobronchial lumen, an extrapulmonary cyst develops and, as its epithelial secretion continues, it enlarges by gradual distention.

From the Departments of Surgery and Radiology, The Mount Sinai Hospital of Cleveland.

The Authors

● **Dr. Marks, Cleveland, is Clinical Professor of Surgery, Case Western Reserve School of Medicine; Director, Division of Surgery, The Mount Sinai Hospital.**

● **Dr. Freedlander, Cleveland, is Consultant Surgeon, The Mount Sinai Hospital.**

● **Dr. Bennett, Cleveland, is Associate Radiologist, The Mount Sinai Hospital.**

Bronchogenic cysts may be located in a paratracheal, carinal, hilar, or para-esophageal situation (Fig. 1) and may be spherical, elliptical, or lobulated. They are generally found in the posterior mediastinum or in the posterior portion of the superior mediastinum near the tracheal bifurcation (Fig. 2). Although generally unilocular, the cyst may be multilocular, and its respiratory origin is recognizable by the fact that its thin wall is lined by ciliated columnar epithelium with mucous glands within its wall, which is comprised of cartilage, elastic tissue, and smooth muscle.

It generally contains thick, gelatinous, mucoid material but testimony to recent hemorrhage will be provided by finding a dirty brown discoloration. Secondary infection of the cyst wall will not only destroy the lining epithelium but will result in the contents being frankly purulent. Infrequently the cyst may communicate with or rupture into the tracheobronchial tree with expectoration of secretions or with hemoptysis.

Although Hardy[6] has described the presentation of a bronchogenic cyst in a 10 month old infant, its discovery is usually delayed for several decades as the cysts may be asymptomatic for prolonged periods of time, generally being discovered fortuitously at roentgenographic examination or at autopsy. Symptoms develop as a result of pressure on adjacent structures, leading to episodes of dyspnea or pseudoasthmatic attacks, or else an irritative cough may represent tracheobronchial compression or irritation. Compression of the esophagus may lead to some difficulty with swallowing. Radiographic examination will demonstrate a mediastinal mass in the appropriate situation (Fig. 3) and esophagography may confirm its relationship to the esophagus. Bronchoscopy and esophagoscopy will serve to exclude intraluminal distortion but widening of the carina is noted occasionally. Mediastinoscopy may permit visualization of the edge of the cyst and, in one of our patients, indicated relationship to the tracheobronchial tree.

At thoracotomy, a plane of cleavage becomes readily apparent and the bronchogenic cyst may be dissected from the adjacent structures, namely, esophagus, trachea, bronchial area, pleura, and pericardium, with total removal (Fig. 4).

(II) **Enterogenous Cysts:** These are generally representative of esophageal or gastroenteric cysts and are lined by the appropriate squamous or columnar epithelium. The intimate relationship of the cyst to the esophagus is rarely such that a common muscular layer or communication with the esophageal lumen would preclude its removal and, as enterogenous cysts represent a variant of alimentary

TABLE 1. *Mediastinal Cysts and Tumors, Mount Sinai Hospital of Cleveland, 1947-1967*

I.	**Congenital Cysts:**	
	A. Dermoids	6
	B. Teratoma: Malignant	5
	C. Bronchogenic	6
	D. Pericardio-coelomic	2
	E. Enterogenous	2
	F. Neurenteric	1
II.	**Neurogenic Tumors:**	
	A. Neurofibroma	
	1. Solitary	9
	2. Multiple neurofibromatosis	2
	3. Ganglioneuroma	3
	4. Neuroblastoma	1
III.	**Thymus:**	
	A. Benign	8
	B. Malignant thyoma (2 with Myasthenia Gravis)	3
	C. Thymic cyst	1
IV.	**Intrathoracic Goitre:**	18
V.	**Reticulo-Endothelial Disease:**	14
VI.	**Metastatic Disease:**	3
VII.	**Vascular:**	2
VIII.	**Bronchial Carcinoma:**	13
IX.	**Miscellaneous:**	1

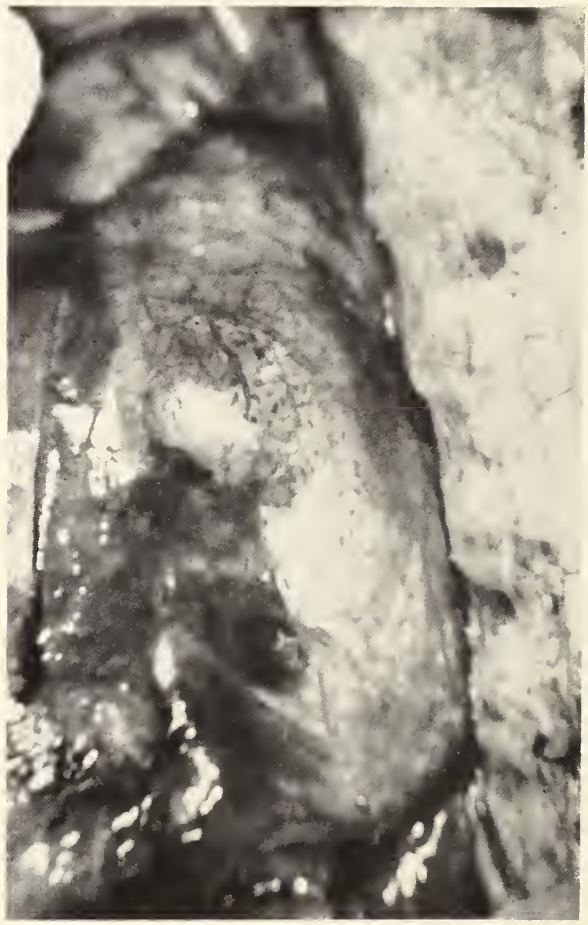


FIG. 1. *Carinal bronchogenic cyst visualized at surgical exploration.*



FIG. 2. *Radiologic demonstration of bronchogenic cyst shown in Figure 1.*



FIG. 3. *Mediastinal mass in posterior mediastinum subsequently confirmed as a bronchogenic cyst.*



FIG. 4. *Bronchogenic cyst removed in toto.*



FIG. 5. *Classic vertebral abnormality associated with neurenteric cyst.*

duplication, an esophagram may, on occasion, demonstrate a fistulous connection to the posterior mediastinal cyst but more frequently, indentation, displacement, or angulation of the esophagus by the mass will be noted. Rarely erosion of vertebral bodies will be visualized radiologically. If the cyst is lined by gastric mucosa, peptic ulceration or erosion may develop and lead to hemorrhage.

(III) **Neurenteric Cysts:** This is a rare mediastinal cyst and results from displacement of tissues representative of the neurenteric canal, giving rise to a posterior mediastinal cyst, which contains tissues of both nervous and alimentary systems. There rarely may be a communication from the dural sheath to the cyst, which lies in front of the spine. Associated abnormality of the vertebral bodies is almost invariably present (Fig. 5).

(B) Dermoid Cysts

Dermoid cysts and teratomas represent, as manifested in this series, the commonest tumors of the mediastinum. These occur typically in the anterior mediastinum where they are situated on the anterior surface of the pericardium or great vessels (Fig. 6). They may vary from simple epidermoid cysts to those of involved histologic composition and may contain mesodermal components such as teeth, hair, or bone. Dermoid cysts generally grow slowly and may remain quiet for years, though trauma with hemorrhage or infection may precipitate more rapid expansion resulting in the cyst wall becoming thickened and adherent to surrounding structures. They may vary in size from that of a walnut to that of a man's head, the largest reported being 30 x 40 x 20 cm. and weighing 5320 gm.[3]

Although classically situated in the retrosternal or cervicoretrosternal situation, they may, on occasion, be situated in the mediastinothoracic or lateral thoracic areas. They usually have a simple vessel contained in a pedicle and being well encapsulated, are easily removable (Fig. 7). Structurally the dermoid cysts are derived from any or all the germinal layers and may have recognizable ectodermal derivatives, such as skin, hair, or teeth. Calcification may be present. In a review of 217 dermoid cysts, Heuer and Andrus found 47 patients who had remained untreated, all dying of the effects of this disease.[7]

The solid teratomatous tumors are almost invariably malignant and, in the present series, all had or developed subsequent malignant propensities. Despite their general solidity, these tumors may contain cystic areas. Death results from the effects of complications which may be those attributable to infection producing sudden and rapid increase in size of the tumor with severe symptoms, or because of subsequent malignant degeneration represented by sarcomatous or carcinomatous histologic patterns.

Thymic Tumors: Shields, Fox, and Lees[11] have indicated that thymic tumors comprise about 10 per

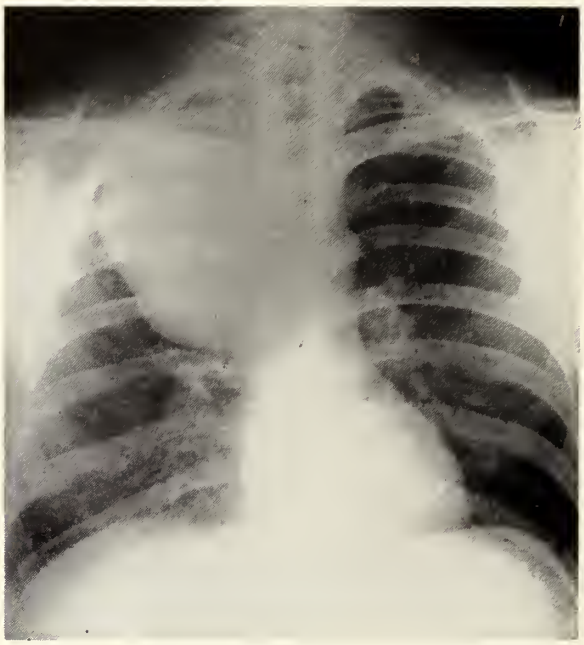


FIG. 6. *Mediastinal dermoid in typical position.*

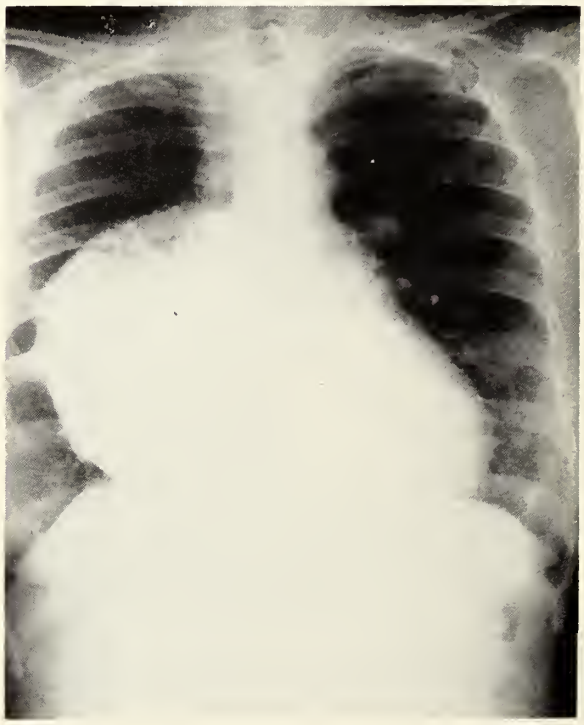


FIG. 7. *Benign mediastinal dermoid readily excised at operation.*



FIG. 8. *Malignant thymoma associated with clinical myasthenia gravis.*

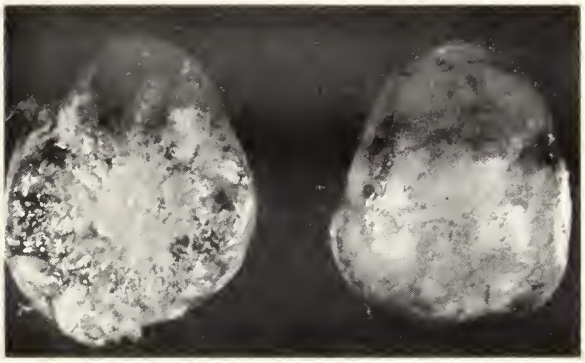


FIG. 9. *Mediastinal neurofibroma after excision from posterior mediastium.*



FIG. 10. *Gross appearance of mediastinal ganglioneuroma.*

cent of mediastinal neoplasms, and the 12 per cent in this series provides fair representation (Fig. 8). Apart from one single simple thymic cyst, there were eight benign noninvasive thymomas and three malignant thymomas, two of which were associated with myasthenia gravis. Myasthenia gravis provides a most important and interesting systemic manifestation of thymic neoplasms, much having been written about this relationship since the first description by Meggendorfer[10] and subsequent reviews by Bell,[1] Blalock,[2] and Keynes.[9] In this series of 12 thymic tumors, the presence of two patients with myasthenia gravis provides an incidence of 16 per cent.

In one patient, thymectomy was carried out with beneficial effects, and, in the other, radiotherapy was first administered but two months later, while awaiting thymectomy, the patient died of myocardial infarction. In the present series, 25 per cent of the thymic tumors were malignant, and, though local extension and invasion of the capsular contiguous structures were prominent, distant metastases were not found.

Neurogenic Tumors: Fifteen patients in this series had intrathoracic neurogenic tumors and, true

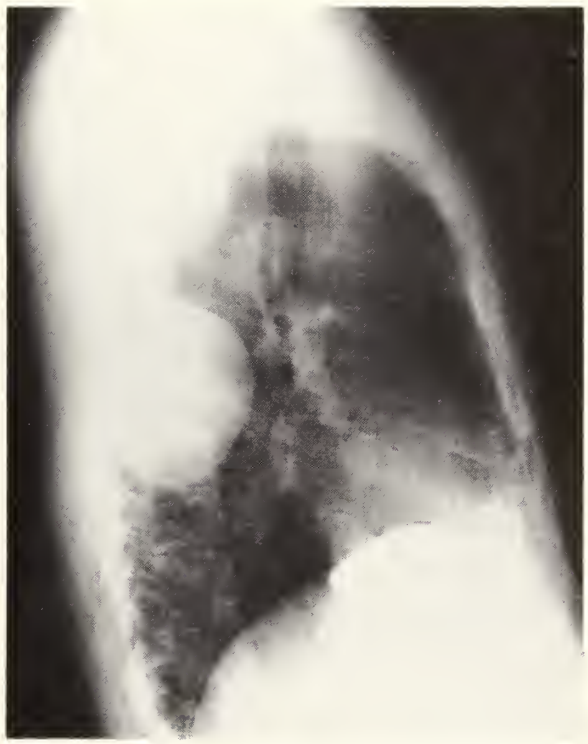


FIG. 11. *Radiologic demonstration of neurofibroma in customary situation.*

to their developmental history, were situated in the posterior mediastinum where nerves and sympathetic ganglia abound. Of the 11 patients with neurofibromas, nine each had a solitary intrathoracic lesion, while in two the intrathoracic lesion was part of generalized von Recklinghausen's disease (Fig. 9). Ganglioneuroma was present in two patients (Fig. 10), while neuroblastoma of extreme malignancy was found in one case. Although most of these tumors

were found at routine roentgenography (Fig. 11), occasionally pain referred along the distribution of a peripheral nerve provided the presenting symptom. One patient treated by the author, but not represented in this series, had an hourglass neurofibroma with an intrathoracic and an intraspinal component, the latter causing spinal cord compression.

Occasionally dyspnea, stridor, and nonproductive cough will provide the presenting symptom. The presence of hoarseness due to recurrent laryngeal nerve involvement or the presence of a Horner's syndrome usually implies malignancy. Diarrhea is an unusual manifestation in children with neuroblastomata, being attributable to the excessive production of catecholamines.

The two main categories of neurogenic tumors are:

A. Nerve sheath tumors
   1. Benign neurilemoma and neurofibroma
   2. Malignant neurofibrosarcoma and fibrosarcoma

B. Sympathetic ganglia
   1. Benign ganglioneuroma
   2. Malignant neuroblastoma and ganglioneuroblastoma

Geschickter,[5] in his studies of tumors of the peripheral nerves, analyzed 850 primary nerve tumors and found 41 per cent to be malignant. Kent and Blades,[8] in a series of 18 surgically treated cases, noted that 41 per cent were malignant on gross and microscopic examination. This conclusion finds no reflection in our series, for, with the exception of the neuroblastoma, all the other removed tumors were considered totally benign.

Diagnosis may be readily established on radiologic examination, which will demonstrate a large single circumscribed nonpulsating rounded mass situated in the superior aspect of the posterior mediastinum (Fig. 12). Erosion of adjacent ribs may result while search for intraspinal extension may be manifested by enlargement of the intervertebral foramen (Fig. 13). Myelography may be indicated under such circumstances. At thoracotomy the tumor is found to be retropleural and situated in the sulcus between rib and vertebral bodies.

Intrathoracic Thyroid: An intrathoracic thyroid constituted the mediastinal lesion in 18 patients in this series. The majority of the lesions proved to be retrosternal extensions of nodular cervical goiters and predominated in middle-aged women. Although some of these have been symptomless and noted only on routine chest x-ray, it is important to appreciate that the size of the lesion may be such as to cause pressure effects on the respiratory system with choking and respiratory difficulty or difficulty with swallowing, especially if the intrathoracic extension occurs into the posterior mediastinum as it occasionally does. Radiologic evidence of tracheal deviation provides good



FIG. 12. *Neurofibroma demonstrated as single rounded nonpulsating mass in posterior mediastinum.*



FIG. 13. *Hourglass neurofibroma with mediastinal and extradural components.*

presumptive evidence of this lesion and calcification is not noted infrequently (Fig. 14). The majority of the intrathoracic goiters are benign and can be removed by the cervical route. In one case in this series, the organ was carcinomatous and could only be surgically removed after splitting the sternum.

Mesenchymal Tumors: Fibromas, lipomas, and xanthomas have been described with an incidence of 4 per cent, but none is represented in this series. Mediastinal lipomas are generally anterior with extension to the root of the neck or to an extrasternal subcutaneous lipoma connected to the retrosternal mass by an isthmus perforating the sternum.

Vascular Tumors: These are rare. In the present series, one angio-endiothelioma was encountered in the anterior mediastinum. An aneurysm involv-



FIG. 14. *Mediastinal goiter with demonstrable calcification.*

ing the arch of the aorta provided diagnostic difficulty and was confirmed to be vascular in origin only at aortographic examination.

Summary

An analysis of 100 patients presenting with mediastinal masses at Mount Sinai Hospital of Cleveland yields 70 patients who had true primary mediastinal cysts or tumors in whom surgical therapy was carried out, providing gross and microscopic examination of the specimens and allowing a follow-up of response subsequent to surgical cure.

The anterior mediastinal masses were generally represented by retrosternal goiter, thymic neoplasms, both benign and malignant, with and without myesthenia gravis, tracheobronchial cysts, pleuropericardial cysts, dermoid cysts, and teratomata. The posterior mediastinum was mainly involved by neurogenic tumors and, predominating among these were neurofibromas, with ganglioneuromas, neuroblastomas, and the occasional neuroepithelioma being found.

Dermoid cysts and teratomas represented the most common tumor of the mediastinum in this series, being found typically in the anterior mediastinum.

The role of radiographic examination, the use of endoscopy, and the occasional use of mediastinoscopy have all helped to provide accurate preoperative diagnosis, while the esophagogram has provided helpful information regarding the relationship of cyst or tumor to the structure. Although several of the patients were asymptomatic, the condition being discovered at routine roentgenologic examination, symptomatic lesions resulted from compression or irritation of the tracheobronchial system and the esophagus, while in several cases vascular compression provided the dominating feature.

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ATRIAL PACING can be used as a safe test in the assessment of patients with angina pectoris. The results are useful in clinical judgments, and this method of investigation may be indicated for patients in whom the diagnosis of angina pectoris is in doubt or who are being considered for surgical treatment of ischemic heart disease. — Raphael Balcon, M. B., M. R. C. P., William C. Maloy, M. D., and Edgar Sowton, M. D., M. R. C. P., London, England; *British Medical Journal*, 3:91-92, July 13, 1968.

The Use of Cadaver Organs in Transplantation
A Discussion of Ethics and Policies

C. JAMES CERILLI, M.D.

KIDNEY TRANSPLANTATION is an aceptable form of therapy for terminal renal failure, and many problems that initially involved a few physicians now concern a large percentage of the medical profession. In its early history, the question of the morality of using living donors as the source of the donor kidney received deep and profound interest. As a result, a set of principles arose that serve to protect the patient, the prospective donor, and the physician. These principles include a thorough and honest discussion with the prospective donor as to the risk and future liability of the donor nephectomy. This discussion is conducted preferably by a physician not directly involved in the surgical aspect of the procedure. In addition, an honest presentation must be made to the prospective donor concerning the long-term prognosis for the recipient. Lastly, an opportunity, preferably on a medical basis, must be made available for a reluctant prospective donor to honorably withdraw from consideration. With these guidelines, ethical surgical behavior is rarely violated when living donors are the source of the homografted kidney.

A similar but potentially less controllable situation exists with the use of cadaver organs, and in many respects the moral issues involved overshadow those associated with the use of living donors. Permissible postmortem ischemia time necessitates early intervention if a functioning graft is to be obtained. This time is particularly critical for cardiac, liver, and pancreatic grafts. It is easy to rationalize the use of premortem hypothermia, heparinization, assisted ventilation, and cardiac assist as being in the best interest of the dying patient when in fact their sole purpose may be to provide a better graft for transplantation. There is no doubt that we have a dual responsibility, namely, to provide a patient with cardiac, liver, or renal failure with the best chance of a successful transplant. However, we also have the responsibility of protecting the terminal patient from therapy that is not in his interest. Hypothermia, heparinization, and other measures may or may not influence the clinical course of a terminal patient, but once the principle has been violated, the path is open to more aggressive and less justifiable methods of obtaining suitable cadaver grafts.

The Author

● **Dr. Cerilli, Columbus, is Assistant Professor, Department of Surgery, The Ohio State University College of Medicine.**

The abuse of cadaver grafts is currently a theoretical problem, as in the developmental stage of transplantation, medical centers for the most part have had exemplary conduct in their obtaining of cadaver organs. Yet it may be valuable to consider certain principles that might guide the obtaining of cadaveric grafts in the future. For instance, in order to avoid any question of dual interest, potential donors of a cadaveric organ should be under the care of a physician who is not directly involved in the transplantation procedure. It is not the intention of this paper to discuss the medical criteria of death, but the pronouncement of death must always be by a physician who is not directly involved in the removal of the cadaveric organs. No measures to improve graft viability should be instituted prior to the death of the donor without specific permission from the immediate family. Lastly, permission for use of the cadaveric organ should be obtained by the donor's own physician and not by a member of the transplant team.

The establishment of such principles may never completely eliminate the potential misuse of cadaver organs. However, general acceptance of these principles by the medical community will serve as a deterrent and thus minimize the possibility of a necessary and detrimental restriction in the use of cadaveric grafts.

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Submitted August 14, 1968.

A Clinical Evaluation of Drip Infusion Urography

RONALD J. ROSS, M.D., and JOHN F. BODIE, M.D.

DRIP INFUSION UROGRAPHY, introduced in 1963 by Winchell and Arata[23] and popularized by Schenker[17] and Whitesel and Heller,[22] is considered by most radiologists to be a valuable diagnostic procedure. Many enthusiastic reports[4,9,10,15-19,21] have appeared in the literature. This newer method of examination is now used routinely by Gup and his associates.[8] However, Becker[1] states that the drip infusion pyelogram is not indicated in the initial study of the patient since, in his experience, there is no greater incidence of satisfactory diagnostic studies than with the older method of intravenous pyelography (IVP). The purpose of this paper is to report an evaluation of our experience with 50 consecutive drip infusion pyelograms (DIP) and drip infusion nephrotomograms (DIN).

The complications and sequelae of cystoscopic and retrograde manipulations,[3,7,11-13] high dose injections of contrast medium, information gained, repetition of examinations or unnecessary examinations, financial expenditures, and delay in obtaining the information requested were evaluated.

Method

In this study no cleansing enemas, dietary restrictions, water restriction, or cathartics were given to patients scheduled for infusion studies. In recent publications, dehydration of the patient prior to drip infusion examination is advocated since the contrast agents are osmotically active and act as diuretics[6,14,18] and, therefore, dilution of the contrast material would occur as it is excreted into the pelvicaliceal structures and ureters.[1,19] One cc. of 50 per cent sodium diatrizoate (Hypaque®) per pound of body weight (with a maximum total dose of 150 cc.) is diluted with an equal amount of 5 per cent dextrose in water. The solution is slowly and constantly infused intravenously through an 18-gauge needle during a 6- to 10-minute period. Prior to infusion, a film of the abdomen is taken and subsequent films are obtained at 5, 10, and 15 minute intervals after the infusion is completed. The patient is placed on the tomographic unit in order to proceed more rapidly with tomography if indicated by the five-minute film findings.

If a mass lesion is suspected initially, the DIN is performed at the end of the infusion. One cm. sections from 4 cm. to 11 cm. from the table are obtained. A follow-up kidney, ureter, and bladder film is taken after the tomograms.

From the Department of Radiology, Case Western Reserve University School of Medicine, University Hospitals, Cleveland, Ohio.

Submitted July 10, 1968.

The Authors

● Dr. Ross, Cleveland, is Assistant Clinical Professor of Radiology, Case Western Reserve University School of Medicine; Radiologist, Forest City Hospital; and Consultant in Radiology, Veterans Administration Hospital, Cleveland.

● Dr. Bodie, Cleveland, is Resident, Department of Radiology, University Hospitals, Cleveland.

Results

In a three month period, the drip infusion technic was used in the study of 50 patients. These ranged in age from 8 to 81 years for an average of 54 years and consisted of 26 males and 24 females. Forty of the 50 patients studied initially had routine intravenous pyelograms which were subsequently followed by drip infusion studies. In reviewing all cases (Table 1), the indications for the DIP and the DIN varied, but in 21 of the 50 cases studied the sole reason for obtaining the infusion study was poor visualization of the pelvicaliceal structures and renal contours.

In 43 of the 50 patients in this study there was good concentration within the pelvicaliceal structures and good demonstration of the entire urinary tract. The routine intravenous pyelogram was in no instance better than the drip infusion examination. Fourteen of the 50 patients had retrograde urography either shortly before or after the infusion examination. In only 2 of the 14 patients was the retrograde examination of the kidneys and ureters better than the

TABLE 1 *Evaluation of 50 Consecutive Drip Infusion Pyelograms (DIP) and Drip Infusion Nephrotomograms (DIN)*

Patient	Age	Sex	IVP Results	Infusion Results	Retrograde Results
1	25	M	No IVP	DIN Normal	Normal
2	30	F	Differential Excretion Decreased on left	DIN Excellent filling Bilaterally Normal	None
3	25	F	Calculus Right Upper Pole; Bilateral dilated calices most prominent on right, Poor visualization of ureters	DIP Better Visualization of ureters	Inadequate demonstration of urinary tract
4	8	F	Cyst or inflammatory disease of right kidney	DIN Inflammatory disease	None
5	40	F	Questionable mass left lower pole	DIN Normal	None
6	56	M	Large right kidney; Poor visualization	DIN Better visualization	None
7	81	F	Poor renal contours; Poor visualization on right	DIN Unsuspected cyst left kidney	None
8	78	M	None	DIP Fair visualization of right and non-visualization on left	Hydronephrosis on left
9	80	M	None	DIP Hypoplasia of right kidney	None
10	72	F	Poor concentration; Bilateral hydronephrosis; Right ureter not visualized	DIP Better demonstration of hydronephrosis; right ureter not well seen	Good demonstration Ureteritis cystica
11	58	M	Normal; contours not visualized	DIN Good demonstration of all structures and contours	None
12	66	M	Poor visualization 1 year prior	DIP Good visualization chronic pyelonephritis	None
13	34	M	Poor visualization	DIP Better visualization	None
14	43	F	None	DIN Faint visualization—Normal contours	None
15	60	F	Faint visualization of right hydronephrosis	DIN Better visualization	None
16	70	F	Contours normal—Gas in bowel obscuring pelvicalices	DIN Very good filling equal to retrograde —Fibrolipomatosis	Normal
17	15	M	Normal	DIN (Retrospective) Deviation of left ureter by pheochromocytoma	None
18	47	F	Poor visualization	DIP Good visualization of bilateral hydronephrosis	None
19	71	M	Poor visualization	DIP Good bilateral visualization	None
20	53	F	Normal—good visualization	DIN Normal—better visualization of ureters	None
21	68	M	Poor visualization of calices on left	DIN Good nephrogram and filling, enlarged left kidney	None
22	61	M	Spider calices; incomplete filling on left	DIN Good results—fibrolipomatosis	None
23	36	M	Fullness of right upper collecting system	DIN Better visualization of the contours and pelvicaliceal system	None
24	68	M	Poor filling with spidery pelvicaliceal system on right; question of lesion left	DIP Better filling on right; left kidney indeterminate	None
25	54	F	Incomplete visualization of right renal pelvis	DIN Filling defect, right renal pelvis secondary to prominent mucosa	Normal retrograde
26	38	F	None	DIP Poor demonstration of bilateral hydronephrosis (? retroperitoneal fibrosis)	Better demonstration of collecting systems
27	58	M	Questionable mass in left kidney	DIN Good visualization—normal	None
28	41	M	None	DIP Good visualization—Bilateral hydronephrosis	Retroperitoneal fibrosis-Lysis of adhesions before DIP
29	31	F	None	DIN Good visualization—No extravasation	Bilateral perforation prior to DIN
30	45	F	None	DIN Fair visualization of all structures; chronic pyelonephritis with duplication	Unsuccessful technically
31	74	M	Poor visualization; possible displacement and questionable mass upper pole of right kidney	DIN Large mass lesion on right	None
32	55	M	Poor bilateral excretion	DIP Very good demonstration of all structures	None
33	58	M	Nephrolithiasis on right; right hydronephrosis with partial stenosis at ureteropelvic junction	DIN Good demonstration of renal contours not seen on IVP	None

TABLE 1. (Continued)

Patient	Age	Sex	IVP Results		Infusion Results	Retrograde Results
34	69	M	None	DIN	Enlarged left kidney—Good demonstration of all structures	Unsuccessful technically
35	51	F	Minimal caliectasis on right, previous left nephrectomy for TBC	DIN	Caliectasis on right drip equal to IVP	None
36	74	M	Non-visualization	DIP	Good visualization of bilateral hydronephrosis and hydroureter	None
37	62	M	Incomplete filling of calices and ureters; questionable mass lesion of right kidney	DIN	Normal—Better visualization of all structures	None
38	8	M	Poor visualization and filling of right kidney	DIN	Better visualization of all structures —normal	None
39	42	M	Poor outlines—poor visualization bilaterally	DIP	Better visualization of calices and contours—normal	None
40	53	F	Questionable mass midpelvis of left kidney	DIN	Excellent visualization—normal	None
41	21	M	Poor concentration—extravasation secondary to gunshot wound	DIP	Excellent visualization bilaterally with extravasation	None
42	40	F	None	DIN	Excellent visualization—normal	No better than drip
43	60	M	Poor visualization bilaterally	DIP	Better filling bilaterally with filling of ileal loop	Good visualization with loopogram
44	40	F	Calculus left kidney, questionable filling defect	DIN	Excellent filling multiple cysts left kidney	None
45	31	F	Good filling—questionable mass lesion	DIN	Technically inadequate	None
46	74	F	Good filling-probable mass left kidney	DIN	8 cm. mass in left kidney—probable cyst	None
47	61	F	Poor filling—no visualization of contours	DIN	Much better filling—contours well visualized	None
48	60	F	Poor visualization bilaterally	DIN	Better visualization—normal	Filling defects in right pelvis one month prior to drip
49	75	F	Faint concentration bilaterally	DIN	Good visualization; bilateral small kidneys—probable chronic inflammatory disease	None
50	24	M	Normal	DIN	Better visualization; normal	None

infusion examination for visualization of the pelvicaliceal system and ureters. (Figures 1A and 1B). Bilateral ureteral perforation was produced through retrograde urography in a 31 year old patient.

No urinary or blood studies were performed following the drip infusion studies and no major allergic reactions were encountered.

Discussion

The DIP and the DIN are relatively new examinations only recently added to the radiologists' and the urologists' diagnostic armamentarium. The exact criteria for the use of the DIP and the DIN must be stated since, with a staff of many radiologists and many urologists, the criteria for further studies of the urinary tract differ significantly. Furthermore, the suggestion of the radiologists for further evaluation of the urinary tract is not always followed by the referring physicians. In certain clinical situations a drip infusion examination should be performed as the initial study to avoid repeated and unrewarding initial routine intravenous pyelography as well as retrograde pyelography. This would include those patients with the blood urea nitrogen (BUN) elevated to 120 mg./100 cc. obesity, suspected or known hydronephrosis, suspected renal tumors or cysts, suspected obstructing or partially obstructing renal calculi, unsatisfactory previous IVP, previous urologic procedures such as ileal pouches (Figs. 2A and 2B), renal inflammatory disease, trauma (Figs. 3A and 3B), and in children with suspected congenital abnormalities.

The nephrogram effect observed results from the large urine flow (4 to 10 cc. per minute)[18] produced by the intravenous drip, which floods the renal glomeruli and tubules causing filling and distension of these structures. The urine enters at a rate which exceeds the ability of the tubules to empty into the renal pelvis and a state of relative obstruction and stasis occurs. This accentuated and prolonged nephrogram is of value for differentiation of cysts versus tumors. The cysts are radiolucent relative to the surrounding renal parenchyma and have sharp borders (Figs. 4A, 4B, 5A, 5B, and 5C). The tumors are characterized by irregular borders and a tendency towards the same density as the surrounding parenchyma or possibly an increased density. These changes are best demon-



FIG. 1A. *DIP (9-10-66): Excellent demonstration of entire urinary tract. Mild right hydronephrosis secondary to acute angulation of the right ureteropelvic junction.*



FIG. 1B. *Retrograde urogram (9-12-66) adds no further information.*



FIG. 2A. *IVP: Incomplete filling of pelvicalices and ureters following ureteral ileal loop diversion procedure.*



FIG. 2B. *DIP: Better filling and better visualization of the upper urinary tract and ileal loop.*

strated with the DIN. However, nephrotomography may not reveal all types of tumors and subsequent angiography si then indicated (Figs. 6A, 6B, 6C, 6D, and 6E). Fibrolipomatous deposits can be differentiated from space-occupying lesions (Figures 7A and 7B).

With drip infusion pyelography, the ureters are more completely filled and their displacement more easily seen in patients with suspected retroperitoneal nodes or masses (Figs. 8A, 8B). There will be non-visualization of the ureters in some patients with elevated blood urea nitrogen. The liver, spleen, or



FIG. 3A. *IVP following gunshot wound is not of optium technical quality. Poor visualization of the pelvicalices, ureters, and bladder. Extravasation of contrast material is delineated within the pelvis.*



FIG. 3B. *DIP following laparotomy: Excellent visualization of the urinary tract with extravasation from the distal left ureter and demonstration of a pelvic hematoma displacing the ureter and the left border of the bladder.*



FIG. 4A. *IVP: Right superior major caliceal group tilted. Suspected mass lesion right upper pole in a 74 year old male with metastatic carcinoma of the prostate.*



FIG. 4B. *DIN: Large benign cyst of the right upper pole.*

adrenals may be visualized because of the contrast medium within their vascular bed.

Drip infusion pyelography possibly should be considered in all patients over 55 years of age due to the higher incidence of poor visulization of the urinary structures in this age group on the routine intravenous studies.

The drip infusion examinations have no advantage over routine pyelography in patients with hypertension, vague urinary symptoms, general diagnostic urologic evaluations, and in patients with indications



FIG. 5A. *IVP: Calcification in left kidney. Displacement of middle caliceal group of left kidney. There is only fair concentration of the contrast material.*

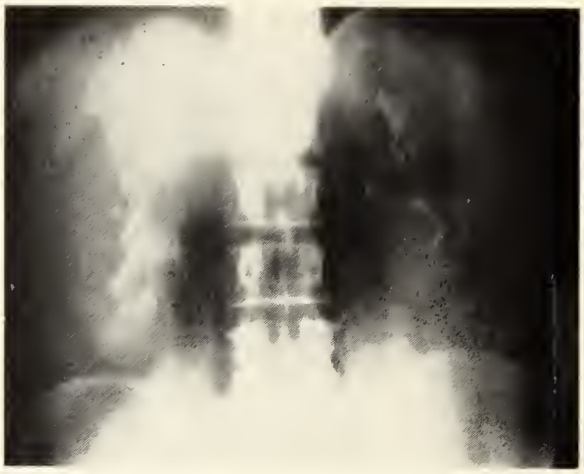


FIG. 5B. *DIN: Radiolucent benign cysts of the upper pole and mid portion of the left kidney.*



FIG. 5C. *Selective left renal arteriogram — Renal vessels stretched around cysts. No tumor vessels.*



FIG. 6A. *DIP (6-3-66): Incomplete filling of left pelvicaliceal system.*

for cystourethrography. These indications account for the majority of IVPs in diagnostic roentgenology.

The possible complications of retrograde urography (Figs. 9A and 9B), the added financial expenditures of inconclusive routine pyelograms, and possible prolongation of hospitalization must be considered, in order to better evaluate the urinary tract.

Reports of virtually total replacement of the retrograde examination or preference for the infusion studies have appeared in the literature.[2,4,8] There are no increased physiologic or anatomic sequelae secondary to large dose injections or infusions of pyelographic contrast media as compared to routine IVPs. In fact, better tolerance to infusion examination than to the routine pyelogram has been observed.[4] Gup[8] reported on ten patients following drip infusion studies and none had changes in blood urea nitrogen, blood pressure, or pulse rate. There was a marked increase in urine volume and osmolar clearance. There was also a trend toward a decrease in renal plasma flow and glomerular filtration rate. There are no reported changes in the blood urea nitrogen of patients with uremia following the drip



FIG. 6B. *DIN (6-3-66): Renal contours normal. No displacement of pelvicalices.*



FIG. 6C. *IVP (8-3-66): Poor filling of left pelvicalices.*



FIG. 6D. *DIP (11-18-66): Good demonstration of entire "normal" urinary tract.*

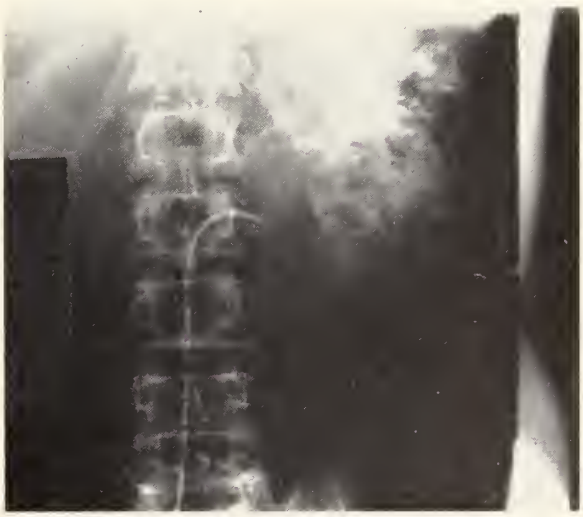


FIG. 6E. *Nephrographic phase of selective left renal arteriogram (11-21-66):, Nephrogram with extensive diffuse tumor stain.*

infusion studies.[15] Creatinine levels are unchanged following drip infusion examinations.[22]

Better visualization of the urinary tract is obtained with drip infusion methods as compared with the double dose method.[10, 20] Also, the administration of a dilute solution of contrast material may result in a decrease in the toxicity which may occur with the administration of a hypertonic solution.[6, 14] The intravenous infusion method also allows a route for the rapid administration of emergency medication in case of severe reaction. Theoretically, the drip infusion examinations can be employed for every renal problem except in patients with sensitivity to the contrast material, oliguria, anuria, or in congestive heart failure. In diabetics, saline may be used instead



FIG. 7A. *IVP: Displacement of infundibula and calices of middle major caliceal group of left kidney.*



FIG. 7B. *DIN: Radiolucent fibrolipomatous deposits around all infundibula and calices.*



FIG. 8A. *IVP: Ureters not completely filled.*



FIG. 8B. *DIP: Left ureter displaced laterally by pheochromocytoma at the L-2-L-3 level.*



FIG. 9A. *Retrograde urogram (11-3-66) with bilateral perforation of the renal pelves.*

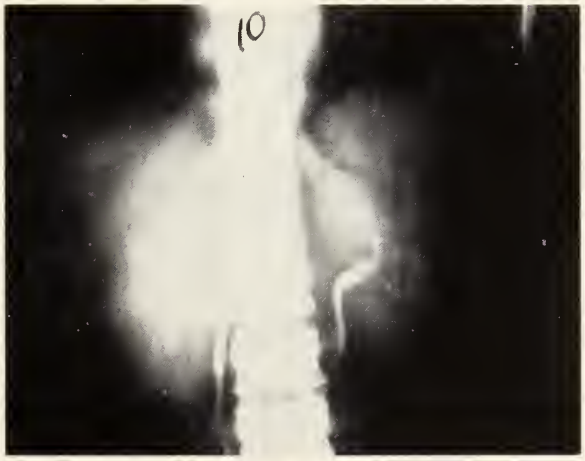


FIG. 9B. *DIN (11-4-66): Good demonstration of pelvicalices with no sequelae of previous perforations.*

of dextrose and water. Patients with multiple myeloma may pass proteinacious casts after pyelograms but these actually may be secondary to dehydration rather than to the contrast medium.[24]

An infusion pyelogram was performed in one patient, not in the 50 cases presented, with a blood urea nitrogen of 90/mg. per 100 ml. There was no visualization of the pelvicaliceal structures and only minimal contrast material in the urinary bladder. The patient subsequently died and the pathologic diagnosis was acute necrotizing renal papillitis. Although the papillary necrosis most likely preceded the infusion, this examination may have further damaged the severely involved renal parenchyma.

Conclusion

Drip infusion pyelogram and drip infusion nephrotomogram should be used as the initial procedure in patients with elevated blood urea nitrogen, obesity, suspected or known hydronephrosis, suspected renal tumors or cysts, suspected obstructing or partially obstructing calculi, previous unsatisfactory IVP, previous urologic procedures as ileal pouches, renal inflammatory disease, trauma, and in children with suspected congenital abnormalities. The infusion examination yields more direct information in regard to urinary tract abnormalities with less delay, risk, and financial expenditure to the patient.

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A Core Curriculum for the Training of Nurses in Coronary Care Unit Functions

RICHARD W. WATTS, M.D.

SINCE the introduction of coronary care units six years ago, their obvious values have caused hundreds of hospitals to institute such units. Each hospital then has had to face the problem of training nurses for this specialized type of nursing. Each hospital also has had to cope with the problems of retaining these specially trained nurses and also retraining them to renew their skills.

Because of the communitywide nature of these problems and the lack of a central agency for this training, medical and nursing representatives of five Greater Cleveland hospitals met in November, 1967 and drew up a core curriculum of 28 hours of instruction (Table 1). The use of the term core curriculum indicated that this was to be a basic course for nurses doing general coronary care unit duty. It was not designed for supervisory personnel for whom there are more prolonged (two to four weeks) and intensive courses elsewhere. These latter courses are excellent but cannot fill the great need for nurses functioning below the supervisory level.

TABLE 1. *Core Curriculum for Coronary Care Unit Nursing*

Subject	Lecture	Practice
Background of Coronary Disease	2 hours	
Cardio-pulmonary Resuscitation	2 hours	4 hours
Arrhythmias—Diagnosis and Treatment	4 hours	16 hours

The main emphasis of the core curriculum is the demonstrated acquisition of these skills by the nurses. This is shown in group and individual contacts between faculty and students as well as in written and oral testing at the end of the course. The results of the final testing on arrhythmias on the first three groups of students are shown in Table 2.

Each course is limited to 20 students with priority given to those nurses already working, or about to work, in a coronary care unit. An attempt is made to diversify the hospital origin of the student body so that no hospital would be delayed in obtaining some trained personnel. All students are required to purchase the text *Intensive Coronary Care—A Manual For Nurses* by Meltzer, Pinneo, and Kitchell.[1]

The Author

● **Dr. Watts, Cleveland, is Chairman, Subcommittee on Coronary Care Units, Professional Education Committee, Ohio State Heart Association; Senior Clinical Instructor, Department of Medicine, Case Western Reserve University School of Medicine.**

The course is sponsored by the Heart Association of Northeastern Ohio which handles scheduling, publicity, and registration. At present, nine hospitals* in Cuyahoga County have cooperated in teaching the core curriculum. The course is given at a different hospital each month. It is usually given during the second week of the month from 9 AM to 4 PM on five consecutive days. No provision has been made for actual work experience in the course but individual arrangements can be made at the sponsoring hospital.

TABLE 2. *Arrhythmia Test Results on Three Groups of Core Curriculum Trained Nurses*

Diagnosis	Correct Diagnosis
Atrial Premature Contractions	50%
Supraventricular Tachycardia	80%
Atrial Flutter	80%
Atrial Fibrillation	50%
First Degree A-V Block	55%
Second Degree A-V Block	80%
Third Degree A-V Block	60%
Ventricular Premature Contractions	60%
Ventricular Tachycardia	70%
Ventricular Fibrillation	80%
Artificial Pacemaker Functioning	80%
Pacemaker not capturing ventricle	17%

While the courses are given by the personnel of each hospital, some teaching aids are shared. These

* Fairview, Euclid General, Huron Road, Lutheran Marymont, Mount Sinai, St. Alexis, St. Luke's, and St. Vincent Charity.

include the films "Prescription For Life" and "Disorders of the Heartbeat," arrhythmia slides and testing material, and "Resusci-Anne" manikins.**

Conclusions

1. The training and retraining of nurses for work in coronary care units constitutes a great and continuing problem for the operation of these units.

2. With the recognition of the communitywide nature of these problems and the development of a core curriculum, community hospitals can successfully provide a cooperative basic training program with considerable success.

3. Nurses can be instructed in recognition of arrythmias, and they quickly gain a high degree of skill.

Acknowledgment: The author wishes to express his appreciation to the many nurses and physicians who gave advice on the core curriculum.

Reference

1. Meltzer, Lawrence E.: *Intensive Coronary Care. A Manual for Nurses,* Philadelphia: CCU Fund, Presbyterian Hospital in Philadelphia, 1966.

** The training films can be obtained from local heart associations.

Submitted August 14, 1968.

OUT OF THE ANNALS

EARLY RECOGNITION OF GLAUCOMA — The incurable blindness resulting from unrecognized and, therefore, improperly treated glaucoma is an old and sad story to all oculists, but this paper is not written for oculists, but for general practitioners. It may occur to you, gentlemen, that this is also an old and oft-repeated story to you. I believe this to be true, and there must be some good reason for such frequent repetition. Glaucoma comprises about one per cent of all eye diseases, and is probably met with more or less frequently by every practitioner. I wish to impress upon your minds three facts in regard to glaucoma: First, it can be easily recognized; second, it can, usually, be easily treated; third, if either let alone or treated improperly, the result is always incurable blindness. I have also a conviction which I believe to be a fact, namely, that the general practitioner almost always fails to recognize this disease. If this be true, and if you accept my previous statements, the conclusion cannot be avoided that hundreds, yes thousands, of people become blind every year through the carelessness of their family physician. These are harsh words, but I believe it to be for the good of the profession that they be spoken. . .

Pardon me, gentlemen, if I insist strongly upon two points:

First. Do not mistake glaucoma for neuralgia, iritis, cataract, or acute conjunctivitis. The mistake is always a fatal one.

Second. When in doubt use eserine. You can do infinitely more harm in glaucoma with atropia than you can in any other disease with eserine. — Harlan P. Allen, M. D., Columbus, Ohio, Professor of Ophthalmology and Otology in Columbus Medical College — Transactions of the Ohio State Medical Society, 1888.

Maternal Deaths in Appalachia*

By the OSMA COMMITTEE ON MATERNAL HEALTH

DURING THE PAST FEW YEARS, a keen focus has been placed by The National Administration upon certain areas of several states known as "Appalachia." Attention has been centered particularly upon the relatively impoverished conditions existing in these regions with respect to the social, economic, and health status of the human beings residing therein.

Completely cognizant of the implications pertaining to Maternal Health in these regions, The OSMA Council, on numerous occasions, has requested that a survey be conducted by the Committee on Maternal Health, to determine the validity of various claims and statements, pertaining to Ohio, advanced through the press and other media.

Hence, in compliance with requests of The Council, after months of study and research, the Committee on Maternal Health submits the following report.

Appalachia

In Ohio, the *area* known as "Appalachia" includes 28 counties filling the southeast portion of the State (see Fig. 1). Their distal border faces the Ohio River. Inhabitants, facilities and industries are served in a program under enactment of the Appalachia Regional Development Act of 1965.

Selected comparative geographic, demographic, and economic data are presented in Table 1.[1] Although Ohio's Appalachia (28 counties) covers approximately *half the area* of the remaining counties, its population is only *one-eighth* of the latter. However, its population does appear to be much more stable (less percentage change), with more than *twice* the per cent of rural farm land, and almost three times the rural *non-farm* area, in comparison to Non-Appalachia. In Appalachia 26.7 per cent of the families have an income less than $3,000, yet figures representing families having a telephone and a car compare favorably for both the southern and northern counties of the State.

Health Personnel and Facilities

A valiant attempt was made to obtain reliable statistics related to health personnel and facilities in both the *Appalachian* and *Non-Appalachian* regions of the State, in order to provide a realistic comparison. Innumerable sources were explored; at best, only a few submitted figures could be utilized.[1-3] Many of these were integrated into a useful common denominator by mathematic interpolation (Table 2). Hence the final figures published represent solely a practical estimate, particularly in the Non-Appalachian area of Ohio. The transient state of migratory personnel, coupled with a delay or omission in



FIG. 1. *The 28 Counties in Ohio's Appalachia Program*

*A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the State. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review. Occasionally, special reports are published by the Committee.

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prompt, accurate reporting of change in status (retirement, removal from State, etc.), contribute deeply to the inaccuracy of figures available.

Methodology

As a matter of convenience, for this special survey (known as Project No. 53), research was directed to a ten-year period, 1955 to 1964, inclusive. Thus, comparative figures are available utilizing those published by the Committee in its Ten Year Study of Maternal Deaths in Ohio (1955-1964)[4] as a control.

Critical data pertaining to the 28 counties of Appalachia was developed for this area, using a similar IBM data processing system, properly oriented.

The total number of *live births* reported for Appalachia by the Division of Vital Statistics, Ohio Department of Health, for the ten years under study was 240,950 (Table 3). Although the peak of all years was reached in 1957, it is noted that the yearly average remained fairly stable, declining only by 3,483 live births in 1964.

On the other hand, for the total State of Ohio, while the peak of live births was also observed in 1957, a marked progressive decline occurred in subsequent years through 1964 (Fig. 2).[5]

TABLE 1. *Geographic, Demographic, and Economic Data, Appalachia and Non-Appalachia, Ohio.*[1]

Factor	Ohio, Appalachia[1]	Ohio, Non-Appalachia
Number of Counties	28	60
Area, Square Miles	13,698	27,524
Population, 1960 Census	1,119,555	8,962,522
Population Density	81.7	288
Pop. % Change 1950-60	8.2	23.3
% Rural Farm	11.7	4.8
% Rural Non-Farm	50.3	18.7
Per Capita Income	1,460	2,003
% Family Income less than $3,000	26.7	14.5
% With Phone	72.3	86.1
% With Car	81.4	83.2

TABLE 2. *Health Personnel and Facilities, Appalachia and Non-Appalachia, Ohio, 1962-1964*

Factor	Ohio, Appalachia[1]	Ohio, Non-Appalachia[2]
Hospitals*	32	184[2]
Number of Beds *	3,174	37,091[2]
Health Personnel:**		
Physicians, M. D. & D. O.	730	13,852[3]
Dentists	350	4,748[3]
R. N.'s	2,440	44,558[3]
Health Dept. Personnel	209	***

* Short Term, Long Term, V. A., & Lic. Nurse Homes Omitted.

** Estimated figures include retired personnel, faculty, research, and personnel licensed but moved to other states.

***Not available.

TABLE 3. *Live Births By Year (10 Years) 1955-1964, Counties in Appalachia (Ohio)*

Year	Live Births
1955	23,521
1956	24,767
1957	25,731
1958	24,951
1959	24,997
1960	24,333
1961	24,593
1962	23,212
1963	22,597
1964	22,248
10 Year Total	240,950

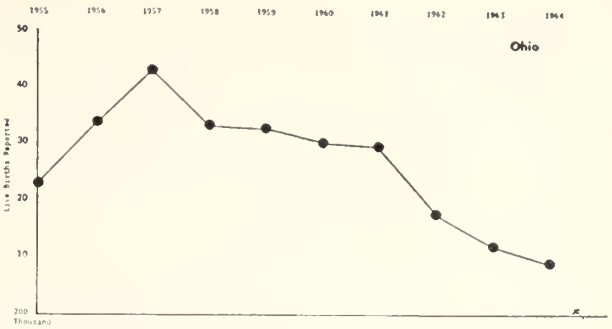


FIG. 2. *Number of Ohio Live Births Per Year, 10 Years, 1955-1964. (From the Division of Vital Statistics, Ohio Department of Health)*

On the other hand, for the total State of Ohio, while the peak of live births was also observed in 1957, a marked progressive decline occurred in subsequent years through 1964 (Fig. 2).[5]

Maternal Mortality in Appalachia

In the following column, maternal mortality statistics for Appalachia (ten years) are presented. They are published in a prescribed format to permit comparison with similar reports issued in the past by the Committee. Uniform terminology and nomenclature utilized in previous reports are employed; they follow closely those prescribed by the World Health Organization in The International Classification.

Several members of The Council made queries concerning the number of obstetric deliveries which were attended or unattended. The results of this phase of investigation are tabulated in Table 4.

Discussion

Comparing the Appalachia area of Ohio to the Non-Appalachia area, as stated above, the ratio of populations is *one* to *eight* respectively. Although the *number* of short term hospitals listed in each area (Table 2) is proportionately greater in Appalachia (one to six), the actual number of beds is proportionately less (one to eleven), reflecting a predominance of smaller institutions in the southern area. For whatever value the figures may have, it appears that health personnel in a similar comparative ratio are markedly diminished in the Appalachia region.

Rather remarkable, as stated above, the annual number of live births reported for the ten-year period has remained *more* stable than those reported for the same period in the northern area. This may be due, in part, to the transient character of the population in the Non-Appalachia region (23.3 per cent population change, Table 1). Or, the instability may be due to

changes in development of industrial projects found in the north sector.

TABLE 4. *Delivery Attendance, 57 Maternal Deaths, Counties in Ohio Appalachia (10 Years) 1955-1964*

Gestation	Unattended	Undelivered	Physician	Nurse	Midwife	Not Recorded
Ectopic		1	3			1
Abortion	1	2	3			
Immature		1	1			
Premature		7	5			
Term		5	25	1	0	1
Totals	1	16	37	1	0	2

Ohio Maternal Mortality Study, 10 Yrs., 1955-1964;
Statistics for Appalachia, 28 Counties

Total Live Births in Ohio, 88 Counties, 10 Years 2,300,535
(Total Cases in files, 10 years, 1955-1964) 1,080

Appalachia (28 Counties), Total Live Births, 10 Yrs. 240,950
- Cases Studied 90
- Cases Not Studied Due to Lack of Information 16
- Non-maternal Deaths, Appalachia, 10 Years 17

Maternal Deaths (Appalachia) 10 Years 57
- Non-White 5
- White 51
- Not Recorded 1

Age:
- Teens 3
- 20's 25
- 30's 23
- 40's 5
- Not Recorded 1

Parity:
- Primigravidae 12
- Multiparae 43
- Unknown 2

Place of Death:
- Hospital 47
- Home 9
- Other 1

Type of Delivery:
- Not Recorded 1
- Operative 29
- Nonoperative (spontaneous) 11
- Not Delivered 16

Route of Delivery:
- Not recorded 0
- Vaginal 22
- Cesarean (antemortem) 14
  - *(postmortem) 6
- Laparotomy (ectopic preg.) 5
- *Not Delivered 16

Case Classification: (when death occurred)
- Not known 0
- Group I (fr. concept. to 20th wk.) 3
- Group II (fr. 20th wk. to 28th wk.) 1
- Group III (fr. 28th wk. through term) 12
- Group IV (postabortal, postpartum) 41

Autopsies 32
(includes 3 coroners' cases)

Prenatal Care (apparent from data sheets)
- None 4
- Unknown or not reported 7
- Adequate 23
- Inadequate 15
- Excluded (ectopic preg. and abortion) 8

Classification of Preventability:
- Nonpreventable 21
- Preventable (avoidable factor) 36
  - Patient responsibility (P_1) 7
  - Personnel responsibility (P_2) 22
  - Both P_1 and P_2 7
  - P_3 (Misc.) 0

Classification of Primary Causes of Death:

Hemorrhage 22
- Abortion, without sepsis 1
- Abruptio 1
- Afribrinogenemia* 1
  - Abruptio 0
  - Am. Fl. embolus. 1 0
- Dead fetus 0
- Atony, uterine, Postpartum 2
- Ectopic Pregnancy (without sepsis) 5
- Laceration, extrauterine 2
- Placenta Praevia 3
- Retained Placenta 0
- Ruptured uterus (no afibrin.)* 7
- Other 0

High Risk Related: 3 *Non-Related*: 1

Infection 6
- Abortion, alleged "criminal" 1
- Abortion, septic, induced 0
- Abortion, septic, spontaneous 0
- Up. Resp. Inf. 0
- Peritonitis 3
- Septicemia (puerperal sepsis) 1
- Septicemia (other) 1

High Risk Related: 0 *Non-Related*: 1

Toxemia 7
- Hypertension, chronic (incl. Hypertension with cerebrovascular hem.) 1
- Eclampsia 4
- Hyperemesis Gravidarum 0
- Preclampsia 1
- Renal Disease 1

High Risk Related: 1 *Non-Related*: 0

Other 22
- Amniotic fl. emb. (no hemorrhage) 0
- Anesthesia 2
  - (general) 1
  - (regional) 1
- Cardiac Disease 6
- Homicide 1
- Intestinal obstruction 1
- Ileus, paralytic 1
- Lower Nephron Nephrosis 1
- Puerperal Psychosis 1
- Pulmonary Edema 1
- Pulmonary Embolus 7
- Shock, inverted uterus 1

High Risk Related: 7 *Non-Related*: 4

Analysis of the maternal mortality statistics for Appalachia in direct comparison with those of the northern counties is not made in this report due to a lack of space. Figures for the 88 counties as a whole have been published in detail in a ten-year survey.[4]

Primarily, 57 maternal deaths in Appalachia were screened by the Committee for the ten-year period 1955-1964. Based upon 240,950 live births reported for the same interval, a maternal mortality rate of 2.37 per 10,000 live births is established for the 28 counties. For the same period, a maternal mortality rate of 3.55 per 10,000 live births is calculated for the remaining 60 counties of Ohio.

However, the reader will note that of the 90 cases studied by the Committee in counties of Appalachia, 16 cases were not studied due to lack of information! Recorders reported that innumerable efforts to secure data on these cases were futile.

Scanning the data related to the 57 maternal deaths, certain items are noteworthy:

Of the 57 mothers, 51 were white; 43 were multigravidous; 47 died in hospitals, 9 died at home, and 1 died en route to an institution. Fourteen died in connection with Cesarean section; six of those who died undelivered had a postmortem Cesarean section.

Sixteen of the 57 patients died undelivered; 12 of these were in the last trimester of gestation (Group III). Well over half (32) of the 57 patients were submitted to autopsy examination.

Hemorrhage, as a primary cause of death, led the list with 22 patients; of these, seven had ruptured

uterus. This proportion compares favorably with the 63 deaths from ruptured uterus among 206 maternal deaths from hemorrhage, reported in the 10 Year Survey for Ohio.[4] Three of the 22 had *related* "high risk" condition.

While three of the six cases associated with infection had peritonitis, only one followed criminal abortion.

Four cases of toxemia were listed as eclampsia, one of which had a *related* "high risk" condition.

Among 22 *other* primary cases of death, pulmonary embolus led with seven cases, followed by six cases of cardiac disease. In this group, *seven* had related high risk conditions existing prior to pregnancy.

In answer to the query concerning "Delivery Attendance" (Table 4.), 37 of the 57 patients were attended by a physician during delivery. One was attended by a nurse, and only one (abortion) was unattended. These figures appear quite favorable when 16 of the 57 died undelivered; two cases were not recorded. No deliveries reported were attended by midwives.

Summary

1. Pursuant to requests of The Council, a survey of maternal deaths in the Appalachia region of Ohio is presented.

2. Selected geographic, demographic and economic data are compared, Appalachia vs. Non-Appalachia counties, together with certain health personnel and facility factors, in Ohio.

3. Brief selected statistics are published concerning 57 maternal deaths in Appalachia, screened during 10 years, 1955-1964, by the Committee.

4. Factors and data concerning the 57 maternal deaths are discussed. The maternal death rate for 10 years, for Appalachia was calculated to be 2.37 per 10,000 live births. Although this is slightly lower than the rate for the same period in 60 remaining counties of Ohio, 16 cases were not studied due to lack of information.

Recommendations

1. The Committee recommends that facets of an educational program related to maternal health and maternal mortality be made available to physicians and allied disciplines in Appalachia. Special attention should be directed to the accumulation of data and completion of patients' records.

2. Plans should be drafted in a program to produce an accurate census of Health Personnel and Facilities in Ohio (Table 2).

Respectfully submitted,

ANTHONY RUPPERSBERG, JR., M. D., *Chairman*
Committee on Maternal Health

Approved by The Council of the Ohio State Medical Association, September 14, 1968.

References

1. Report of The Health Advisory Committee to The Appalachian Region Commission, March, 1966.

2. Personal Communication, Ohio Hospital Association.

3. Personal Communications: Ohio State Medical Association, Ohio Osteopathic Association, Ohio State Dental Board, and Ohio Nurses Association.

4. OSMA Committee on Maternal Health: Maternal Mortality Report for Ohio; A 10-Year Survey, 1955-1964. *Ohio State Med. J.*, 63:323-332 (March) 1967.

5. OSMA Committee on Maternal Health: Maternal Mortality Report for Ohio - 1963. *Ohio State Med. J.*, 62:585-589 (June) 1966.

DEMAND FOR MEDICAL CARE. — We are close to the beginning of a new day for medical care in the United States. If we can quiet our fears and restrain our passions, if we can credit the other fellow with a modicum of good sense and a sprinkling of good will, if we can forget the battles of the past and concentrate on the problems of today and the promises of tomorrow, we can be true both to ourselves and to our responsibilities to the American people. — Victor R. Fuchs, New York City: *The New England Journal of Medicine,* 279:190-195, July 25, 1968.



NEWS AND Organization Section

Proceedings of The Council...

Matters Discussed and Actions Taken at Regular Meeting in Columbus, September 14 and 15, 1968

A REGULAR MEETING of The Council of the Ohio State Medical Association was held at the Imperial House (North), 900 Morse Road, Columbus, Ohio, September 14, 15, 1968. Those present on Saturday, September 14, were: All members of The Council; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. David Weihaupt, Chicago, AMA Field Representative; Dr. Emmett W. Arnold, Columbus, Director, Ohio Department of Health, present by invitation; Dr. Robert E. Tschantz, Canton, AMA Delegate and a member of the OMI Liaison Committee; AMA Delegates: Dr. John H. Budd, Cleveland, chairman of the delegation; Drs. Carl A. Lincke, Carrollton; Frederick P. Osgood, Toledo; George W. Petznick, Cleveland; and Charles A. Sebastian, Cincinnati; AMA Alternates: Harry K. Hines, Cincinnati; Frank H. Mayfield, Cincinnati; Lawrence C. Meredith, Elyria; Horatio T. Pease, Wadsworth; and Frank F. A. Rawling, Toledo; Dr. Gordon M. Todd, Toledo, and Dr. Frank L. Shively, Jr., Dayton, members of the Board of Directors of Ohio Medical Indemnity, Inc., present by invitation; Messrs. Page, Edgar, Gillen, Campbell, Clinger, and Moore of the OSMA Headquarters Office.

Those present on Sunday, September 15, were: All members of The Council; Mr. Stichter; Mr. Weihaupt; AMA Delegates: Drs. Budd, Tschantz, and Petznick; AMA Alternates: Drs. Crawford, Hines, and Pease; Dr. Anthony Ruppersberg, Jr., Columbus, Chairman of the Committee on Maternal Health, present by invitation; Messrs. Page, Edgar, Gillen, Campbell, Clinger, and Moore of the OSMA staff.

Minutes Approved

The minutes of the meetings of The Council held May 15 and May 17, 1968 were approved by official action.

Reports by Councilors

The Councilors reported on the activities in their respective districts.

Ohio Medical Political Action Committee

Dr. Frank H. Mayfield, Cincinnati, chairman of the Ohio Medical Political Action Committee, addressed The Council.

Membership Statistics

Mr. Page presented membership statistics as follows: OSMA membership as of September 1, 1968 was 10,034, compared to a total membership of 10,021 on September 1, 1967. Of the 10,034 members, 8,704 were affiliated with the AMA.

Policy on Waiver of Dues for 1969

By official action, The Council adopted the following policy on waiver of annual dues for the calendar year 1969:

(A) That dues for new members in practice, affiliated with the OSMA during the last six months of the calendar year 1969, namely, July 1 to December 31, inclusive, shall be $25.00, one-half the regular per capita dues of $50.00. The prorating of dues shall not apply to former members reaffiliating.

(B) That the following procedures shall apply during 1969 with respect to OSMA annual dues of members on temporary military service and not making military medicine a career.

(1) State Association dues for 1969 shall be waived for members on temporary military service and not making military medicine a career.

(2) State Association dues for 1969 shall be waived for physicians who were members of the Association in 1968 and who enter such services during the calendar year 1969 before the payment of 1969 dues.

(3) A refund of membership dues will not be made if a member enters such services in 1969 after his 1969 dues are received at the Columbus office of the Association.

(4) The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

(C) Annual Ohio State Medical Association dues for 1969 for a physician serving in an internship or residency program approved by the AMA Council on Medical Education who meets the membership eligibility requirements of the OSMA and who is accepted into membership by a component medical society shall be $7.50. Such intern or resident shall be entitled to receive *The Ohio State Medical Journal* as a part of his membership privileges.

Amendment to OSMA Bylaws

The Council requested the OSMA legal counsel to draft in final form, for presentation at the next meeting of The Council, an amendment embodying the intent of Substitute Resolution No. 4 (citizenship of members), passed by the House of Delegates in 1968, such amendment to be presented at the 1969 meeting of the House of Delegates for final action.

The legal counsel also was instructed to draft a provision to the Constitution and Bylaws clarifying the requirement that county medical society members be members of the Ohio State Medical Association, such resolution to be presented at the 1969 meeting of the House of Delegates.

The Council instructed the legal counsel to draft suggested provisions to amend the Bylaws of the Ohio State Medical Association to provide for recall and disciplinary procedures for officers.

Welfare Plans of Texas and Wisconsin

Mr. Charles W. Edgar and Mr. Herbert E. Gillen reported on their investigation of the administration of Title 19 and other welfare plans in the states of Texas and Wisconsin. The reports were received for information.

Ohio Welfare Medical Programs

An Ad Hoc Committee, appointed by Dr. Light, submitted the following statement which was, by official action, **adopted** by The Council:

Resolution I—The Council of the Ohio State Medical Association recommends that the Ohio Department of Public Welfare establish a relationship with physicians of this state that will permit active physician involvement and direction in both the policies and the mechanisms of welfare medical care programs in Ohio.

Physicians, through the Ohio State Medical Association, will investigate, research, promote, and instigate the mechanism of payment for medical services rendered welfare recipients. This will include supervision, method of disbursement of fees, appraisal of fees for services rendered, and a means of resolution of differences.

Resolution II—The Council strongly endorses transfer of Ohio Welfare medical services payments to a private or voluntary medical insurance plan.

Resolution III—The Council recommends that Ohio Medical Indemnity consider applying for a contract for its services in the administration of medical payments for physician services to welfare recipients in Ohio.

Members of the Ad Hoc Committee were: William R. Schultz, M. D., Wooster, chairman; Dwight L. Becker, M. D., Lima; Robert E. Howard, M. D., Cincinnati; Paul N. Ivins, M. D., Hamilton; P. John Robechek, M. D., Cleveland; and James L. Henry, M. D., Grove City.

American Medical Association

Minutes of meetings of the Ohio delegation held May 14 and July 24, 1968 **were accepted** by The Council.

Possible resolutions for presentation at the clinical session of the AMA at Miami Beach, December 1-4, 1968, were discussed.

By official action, The Council voted to send the following message to the executive committee of the Board of Trustees:

"The Council of the Ohio State Medical Association, in session September 14, 1968, opposes the selection of Booz, Allen, and Hamilton as management consultants and urges that they be eliminated from consideration for the upcoming management survey."

Dr. Budd reported on the September 13 meeting of the Ohio delegation to the AMA.

County Medical Societies

Butler County

An amendment to Section 3, Chapter III of the bylaws of the Butler County Medical Society, changing the beginning of the terms of the officers of the society from January 1 to September 1 **was approved,** subject to an amendment to indicate that the fourth sentence of Section 3, Chapter III of the bylaws is to be amended.

Cuyahoga County

An amendment to Sub-section B, Section 2, Article I of the bylaws of the Academy of Medicine of Cleveland, having to do with affiliate membership, **was approved.**

Hamilton County

An amendment to Section 1, Chapter VI of the Code of Regulations of the constitution and bylaws of the Academy of Medicine of Cincinnati involving meeting dates, **was approved,** with minor suggestions for revision in the wording.

Jefferson County

Amendments to Section 2, Chapter I; Section 1, Chapter IV, and Section 1, Chapter V of the bylaws of the Jefferson County Medical Society **were adopted,** with minor editing for clarification.

Summit County

An amendment to Item 5, Section 3 of Chapter II of the bylaws of the Summit County Medical Society, concerning continuation of membership for intern and resident members who leave the county for military service, was considered by The Council. Such amendment **was approved,** providing the limitation of tenure is provided, with three years being the suggested limitation.

Trumbull County

An amendment to the third paragraph of Article V of the Constitution of the Trumbull County Medical Society, adding the chairman of the public relations committee to the society's council **was approved.**

Ohio Medical Indemnity, Inc.

Drs. Frank L. Shively, Jr., Dayton, and Gordon M. Todd, Toledo, representing the OMI Board of Directors, presented a research committee report submitted by Ohio Medical Indemnity, Inc. The report was accepted for information.

Dr. Robert E. Howard, Cincinnati, chairman of the OSMA-OMI Liaison Committee, presented a report of that committee. Dr. Howard reported that he had observed improvement in the staff of Ohio Medical Indemnity, Inc., and that Blue Cross and Blue Shield were cooperating to upgrade Blue Shield contracts through the use of OMI personnel accompanying Blue Cross representatives in calls upon employers. He expressed the hope that OMI consultants would be available in all Blue Cross areas to assist with public relations and upgrading OMI contracts.

The following were named to the committee to select nominees for the OMI Board of Directors: Drs. Howard, Fulton, Ivins, and Tschantz.

Committee Reports

Scientific Work

Minutes of the meeting of the Committee on Scientific Work held on August 7, 1968 were presented by Mr. Campbell.

The suggested theme for the 1969 Annual Meeting, "The Scope of Medicine — Prevention" and the outline for the 1969 scientific program **were approved.**

Approval of the minutes included the authorization for carpeting the exhibit hall, preregistration of members, the operation of a shuttle bus to and from the convention hall, and the reproduction of selected summaries and abstracts of scientific papers for distribution at the meeting.

The Council **approved** the committee's recommendation to eliminate cash awards for scientific exhibits, and requested the committee to increase the quality of the award plaques, with the committee using its discretion in the development of the award program.

The report as a whole **was approved** with the amendments.

Auditing and Appropriations

Minutes of a meeting of the Auditing and Appropriations Committee held July 24, 1968 **were approved.**

Approval of the minutes included the approval of a contribution to the Ohio Chapter, American Association of Medical Assistants, for funds to assist the chapter in hosting the national meeting of that organization in Columbus, Ohio, in 1968; purchase of new chairs for the OSMA-Columbus Academy of Medicine board room; acquisition of dictating equipment; and appropriation of funds for a statewide conference on drug abuse.

Cancer

Mr. Clinger presented the minutes of a meeting of the Ohio Cancer Coordinating Committee, Inc., which met September 8, 1968.

Approval of the minutes included the approval of the reactivation of the Ohio Central Tumor Registry.

Environmental and Public Health

Mr. Gillen presented the minutes of a meeting of the Committee on Environmental and Public Health held on July 10, 1968.

Approval of the minutes included the recommendation that all local medical societies be urged to establish training programs for those persons engaged in emergency health services.

Eye Care

Mr. Clinger reported on a meeting of the Committee on Eye Care held April 21, 1968.

Approval of the minutes included reaffirmation of the OSMA policy with regard to the 1967 amendment to Title 18 (Medicare), as follows:

"1. Every physician should bill directly all patients, regardless of any third party, governmental or nongovernmental, with whom any patient may have an agreement.

"2. The physician should expect to receive his full usual, customary and reasonable fee for his professional services.

"3. If the patient has an agreement contract or arrangement with a third party, the physician is not a part of that agreement, contract, or arrangement. The physician's only contract is with the patient.

"The Committee wishes to emphasize that, where the third party contract does not provide for the payment of certain procedures, the amount to be reduced in third party payment to the patient is a question that must be resolved by those two parties, and not by the medical profession."

Also approved was a proposed conference on visual problems in education to be conducted by a subcommittee of Dr. Robert L. Willard, Toledo, Chairman; Dr. Thomas L. Edwards, Lima, and Dr. Arthur D. Collins, Cleveland. Such conference will include the discussion of a preschool survey of vision and hearing.

A meeting with representatives of the Ohio State Optometric Association to discuss the re-establishment of interprofessional relations was recommended.

Government Medical Care Programs

Mr. Gillen reported on meetings of the Committee on Government Medical Care Programs held on April 17 and September 11, 1968.

Prepaid Group Plans

A statement on prepaid group plans was amended to read as follows:

"The Ohio State Medical Association is opposed to consumer controlled group practice of medicine as not being in the public interest."

Nurse Anesthetists

The Council accepted the Committee's recommendation that the Ohio State Medical Board be requested to seek an Attorney General's Opinion with regard to whether nurse anesthetists should be permitted to bill independently for their services.

Guidelines for County Medical Societies Participating in Comprehensive Health Planning

The Council approved the Committee's recommendations for the following guidelines for county medical society participation in comprehensive health planning, P. L. 89-749, with the exception of the word "each" in the fourth line of paragraph three which is to be deleted. The recommendations are as follows:

"1. We are dedicated to the premise that there will be no interference with present practice of medicine, dentistry, and related healing arts, as stated in P. L. 89-749.

"2. It is imperative that all physicians become active in community affairs, especially relating to the health needs of the community, and take their rightful place of leadership along with other community leaders in expressing their views.

"3. Local medical societies be urged to establish a Committee on Government Medical Care Programs or assign this function to an existing committee; and that reports be given by this committee at society meetings to keep members informed."

Health Manpower Study of Appalachia Region of Ohio

The Council declined to cosponsor with the Ohio Valley Health Services Foundation, Inc., Athens, Ohio, a health manpower study of the Appalachia Region of Ohio, but agreed to furnish technical data to this or other groups doing similar studies.

The minutes of the Committee were approved as a whole, as amended.

Title XIX Subcommittee

The minutes of a meeting of Title XIX Subcommittee of the Committee on Government Medical Care Programs held September 4, 1968, were presented by Mr. Gillen and were accepted for information.

Insurance Committee

Mr. Campbell presented the minutes of the Committee on Insurance held May 26, 1968.

Approval of the minutes included the approval of the appointment of a steering committee to conduct the exploration and clarification of a proposed home health care project. The Council withheld any consideration of endorsement of the project until a complete written outline of the proposal is obtained.

Major Medical Insurance Improvements

Approval of the minutes reaffirmed previous approval, by mail, of improvements in the OSMA sponsored Major Medical insurance coverage.

In-Hospital Insurance Plan Approved

Sponsorship of an In-Hospital insurance plan of the Insurance Company of North America, to be administered by Daniels-Head & Associates, Inc., **was approved** by The Council upon recommendation of the Committee.

School Insurance

The Council amended the report of the committee to ask that the Insurance Committee explore with Ohio Medical Indemnity, Inc., minimum standards for accident insurance coverage for injured students in elementary and secondary schools.

The minutes of the Committee **were approved** as amended.

Laboratory Medicine

Mr. Campbell presented the minutes of the May 1, 1968, meeting of the Committee on Laboratory Medicine with the Board of Trustees of the Ohio Society of Pathologists. The report **was approved.**

Legislation

Mr. Page presented the minutes of a meeting of the Committee on Legislation held May 5, 1968. The minutes were accepted for information.

Maternal Health

Dr. Ruppersberg presented the annual report of the Committee on Maternal Health, covering the study of maternal mortality of 1965. The Council **approved** the report.

Maternal Deaths in Appalachia

Dr. Ruppersberg then presented a report of the Committee regarding maternal deaths in Appalachia. The Council **accepted** the report and recommended its publication in *The Ohio State Medical Journal.*

Medicine and Religion

Mr. Campbell presented the minutes of the August 29, 1968, meeting of the Committee on Medicine and Religion. The report **was approved.**

Mental Health

Mr. Clinger presented the minutes of the May 5, 1968, meeting of the Committee on Mental Health.

Approval of the report included the approval of a questionnaire to be sent with an *OSMAgram* to all OSMA members, seeking information from physicians on their experiences with drug addiction cases.

The minutes also included the recommendation for a two-day conference on drug abuse, previously accepted by The Council.

The recommendation of the Committee, that a condensed version of "The Many Faces of Depression" be offered as a program for meetings of local medical societies, and that committee members offer their services as speakers when requested, **was approved** by The Council.

Mr. Clinger presented the minutes of a meeting of the Committee on Mental Health held August 11, 1968.

The position of the Ohio State Medical Association with regard to the Alliance for Mental Health, as recommended by the Committee, was amended to read as follows:

> "That individual members of the Committee on Health be permitted to audit the Alliance for Mental Health . . . thus providing close liaison between the OSMA and the Alliance."

Approval of the minutes also included approval of the Committee's recommendation that members of The Council, working with Committee members, help to establish local OSMA medical resource committees for each of the state psychiatric hospitals. The purpose of the committees would be to improve liaison and communication between private practitioners and the hospitals, and promote improved medical and psychiatric care for the patients.

The minutes of the Committee **were approved** as a whole, as amended.

Mr. Clinger then reported on a meeting of the Subcommittee for 1968 Conference on Drug Dependency, Committee on Mental Health, which met June 9, 1968. The minutes outlined the program schedule for the Conference on Drug Dependency.

Rural Health Scholarship Subcommittee

Mr. Clinger also presented the minutes of the Scholarship Subcommittee of the Committee on Rural Health which met July 10, 1968. The minutes **were approved** by The Council.

School Health

Mr. Clinger presented the request of a School Health Subcommittee for a half-day conference at the 1969 Annual Meeting on the topic of school health, the theme of the conference to be "Doctor, My Child is Flunking." The recommendations of the committee **were approved.**

Mr. Clinger also presented the minutes of the School Health Subcommittee for a half-day conference on athletic injuries at the 1969 Annual Meeting. The Council accepted the minutes and **approved** the actions of the committee.

Redistricting

Dr. Ivins presented a progress report from the Committee on Redistricting. He announced that a letter was being forwarded to all presidents of county medical societies to seek information and

opinions with regard to redistricting. His report was approved.

Nursing

Mr. Gillen presented the minutes of a meeting of the Committee on Nursing held September 8, 1968. A section of the minutes calling for an "R. N. Recognition Day" at the Annual OSMA Meeting was eliminated because of the already full schedule of programs making scheduling impossible. The remainder of the report was approved.

Bank Credit Cards

The subject of bank credit cards and whether physicians should participate in programs involving these cards was explored by The Council. It was voted to request an opinion on this matter from the Judicial and Professional Relations Committee.

Migratory Workers

A communication from the executive secretary of the Toledo Academy of Medicine with regard to laws having to do with migratory workers was referred to the Committee on Environmental and Public Health for consideration.

Proposed Cost Adjustment Program

A communication from Dr. Thomas T. Carroll, Toledo, concerning a proposed cost adjustment program was referred by The Council to the Committee on Public Relations and Economics.

Manuscript on Abortion Laws

A manuscript entitled, "Position Stand of the Ohio Psychiatric Association on Suggested Changes in the Abortion Law of Ohio" was accepted for publication in *The Ohio State Medical Journal* as a news item.

Problems Involving Claims Review

The Council discussed the subject of claims review for an extended period. Subsequently, The Council voted to refer the entire matter to the OSMA-OMI Liaison Committee, with instructions to the committee to prepare a precise definition of the terms "usual, customary and reasonable" with emphasis on the term "reasonable." This definition, when approved by The Council, is to be transmitted to the county medical societies for use in the review of fees.

With regard to a communication from Mutual of Omaha dated May 6, 1968, asking the advice and counsel of the Ohio State Medical Association with regard to mechanisms for reviewing Civilian Health and Medical Program of the Uniformed Services medical claims involving questions of a reasonable fee, The Council cited its action of March 30-31, 1968, answering a question from the Nationwide Mutual Insurance Company as follows:

> ". . . to bring these problems to the attention of the individual doctor in the first instance, to the county medical society in the second instance, and then if there is an impasse, to The Council of the Ohio State Medical Association."

With regard to a letter dated July 16, 1968, from Mr. J. D. Bachman, Divisional Claim Manager of the Equitable Life Assurance Society of the United States, asking for advice and perhaps an opinion on a case in Mahoning County regarding the "prevailing fee program" of the steel industry, the Executive Secretary was instructed to inform Mr. Bachman that the OSMA policy concerns only the usual, customary and reasonable fee and does not cover the so-called "prevailing" fee, and that the OSMA would determine only whether a fee is fair and reasonable under the facts and circumstances of a given case.

Review of Nonmember Fees

The Council expressed the opinion that county medical societies should provide for fee review involving nonmember medical doctors.

Advisory Council Under P. L. 89-749

A letter from Mr. Edward F. Willenborg, Executive Secretary of the Academy of Medicine of Cincinnati, regarding appointments to the Health Advisory Council under P. L. 89-749, was received for information.

Reorganization of Health Agencies

The Council considered Resolution 22, passed by the 1968 OSMA House of Delegates and the subsequent action of the American Medical Association under Substitute Resolution 59 resulting thereof.

Both resolutions, involving proposed reorganization of health agencies, including the establishment of a separate U. S. Department of Health headed by a Doctor of Medicine, were referred to the Committee on Government Medical Care Programs for implementation.

Federal Legislation

Mr. Edgar gave an informal report on Federal legislation.

State Legislature

Mr. Page requested Council consideration of various proposals under discussion for introduction in the 1969 Ohio General Assembly.

The Council approved sponsorship by the Ohio State Medical Association of a bill to define blood

and blood derivatives, tissues, organs, etc., as services rather than commodities.

The staff was instructed to prepare for presentation a bill to define next-of-kin for autopsy purposes.

The staff was authorized to go ahead with OSMA-approved legislation for the licensure of laboratories.

OSMA Mailing List

The Executive Secretary was authorized to provide addressing service for the regional workshops of the Ohio Academy of General Practice, providing the work is done on OSMA employees' own time and that they be paid for their services by the Ohio Academy of General Practice.

With regard to work of the travel committees of the Cincinnati Academy of Medicine and the Cleveland Academy of Medicine, the Executive Secretary was authorized to provide addressing service for these two projects, providing the work is done on OSMA employees' own time and they are reimbursed by the travel committees of the two academies.

Report of Ohio Director of Health

Dr. Emmett W. Arnold, Ohio Director of Health, addressed The Council on a number of matters involving his department.

Comprehensive Health Planning

With regard to comprehensive health planning, he reported that an advisory council has been established and one meeting has been held. The council, he said, is assisting communities in planning agencies, that 85 per cent of the population is covered, and that two agencies have been funded. The Director stated that if county medical societies want representation on local planning councils, such councils will not be approved unless county medical society representatives are so appointed.

Local Departments

He reported that at the present time there are 286 health districts in Ohio, that local health departments are staffed by 183 health commissioners, and there are nine vacancies.

Disaster Preparedness

The Director reported on package disaster hospitals and that the department is seeking affiliation of these units with existing community hospitals.

Committee on Reapportionment Schedules Jan. 8 Meeting

A meeting of the OSMA Committee on Reapportionment will be held in the OSMA Headquarters Office on Wednesday, January 8, beginning at 2:00 P. M., it was announced by Dr. Paul N. Ivins, committee chairman. Any member of the Association who wishes to discuss the subject of reapportionment and/or redistricting is invited to be present.

The concept of reapportionment to bring about more equitable representation of individual physicians throughout the state in the OSMA House of Delegates arose out of Resolution No. 17, presented to the House in 1967. (Refer to July, 1967 issue of *The Journal,* page 947.)

The matter was referred to The Council and the Committee on Reapportionment was subsequently appointed. An interim report was submitted to the House of Delegates at the 1968 Annual Session. (Refer to July, 1968 issue of *The Journal,* pages 819-820.)

This subject is scheduled for additional consideration at the 1969 Annual Meeting, and members of the Committee wish to hear all interested persons before a final report is prepared.

Diseases

The Director reported on incidence of mosquito-borne encephalitis, tuberculosis, heart disease, diabetes, and phenylketonuria. He said that 15 confirmed cases of phenylketonuria have been uncovered since 1967 in approximately 170,000 tests.

Radiological Regulations

The Director reported that regulations pertaining to radiological facilities are coming before the Ohio Public Health Council for hearing and consideration.

Legislation

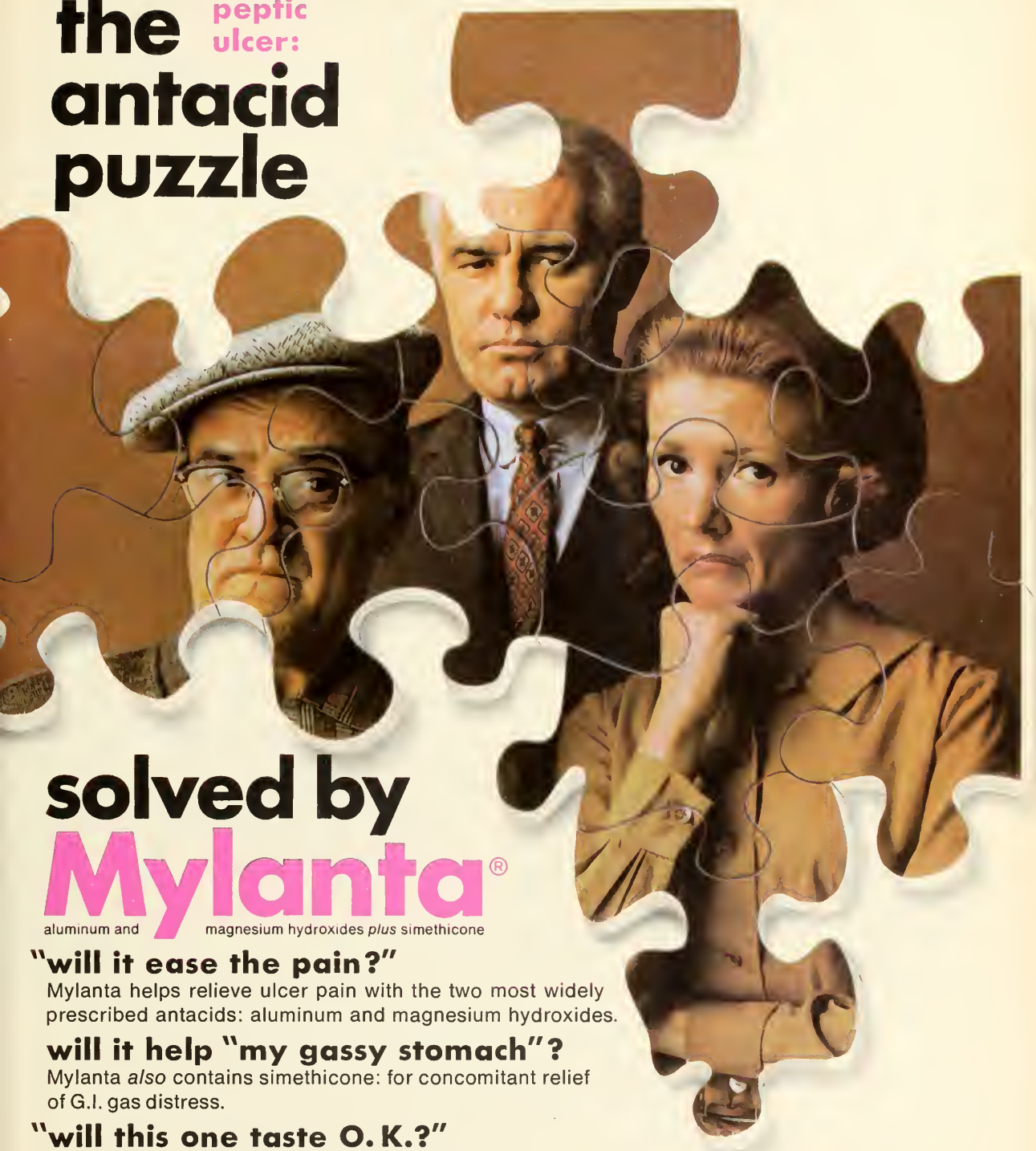
Dr. Arnold stated that legislation in the offing includes extending school immunizations to rubella and requiring tuberculosis testing in the schools. Some consideration has been given to a hospital licensing proposal.

The meeting then adjourned.

Attest: HART F. PAGE
Executive Secretary

the antacid puzzle

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"will it ease the pain?"

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Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

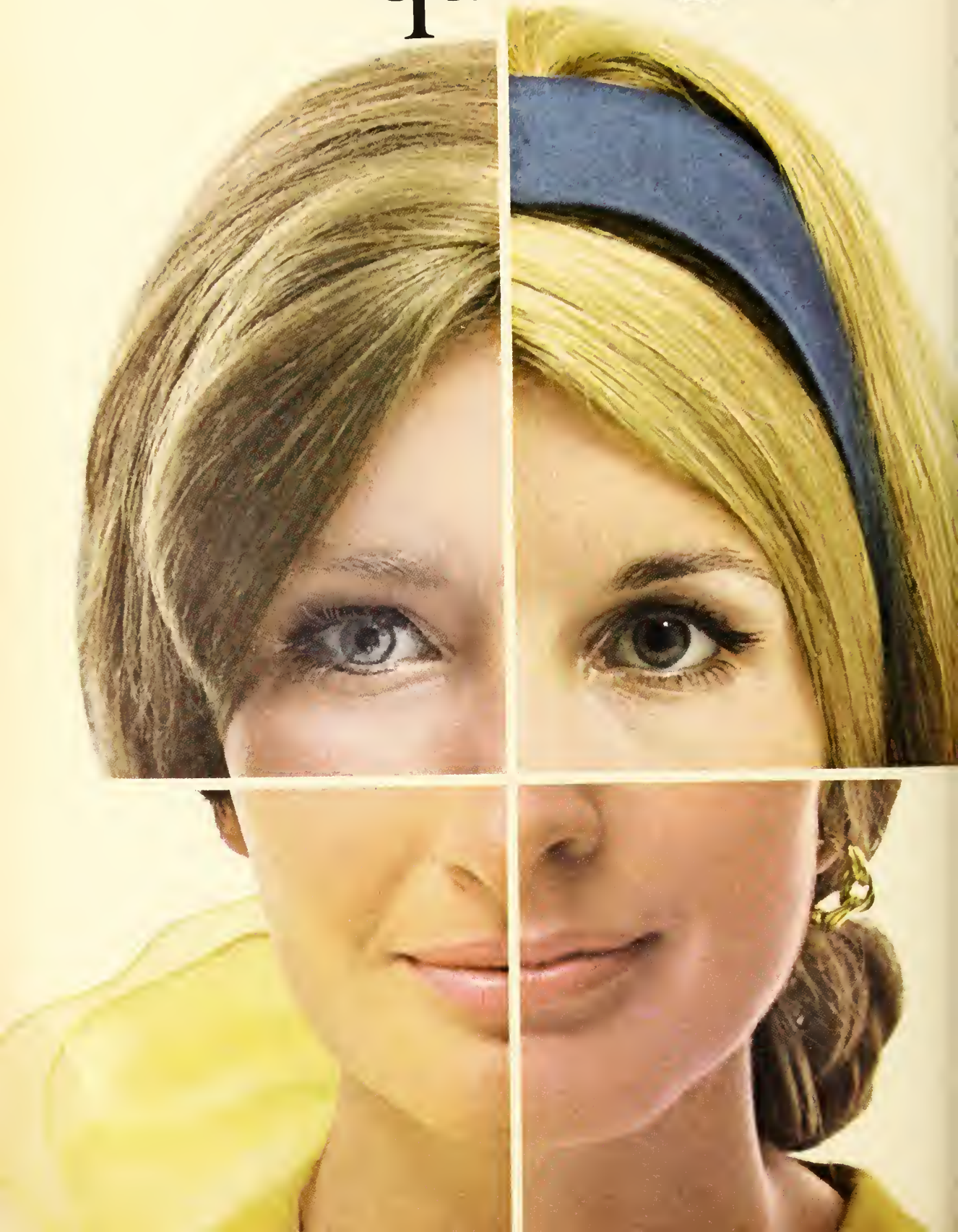
"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

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Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Here is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief.

Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and the aches and pains that almost always accompany upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

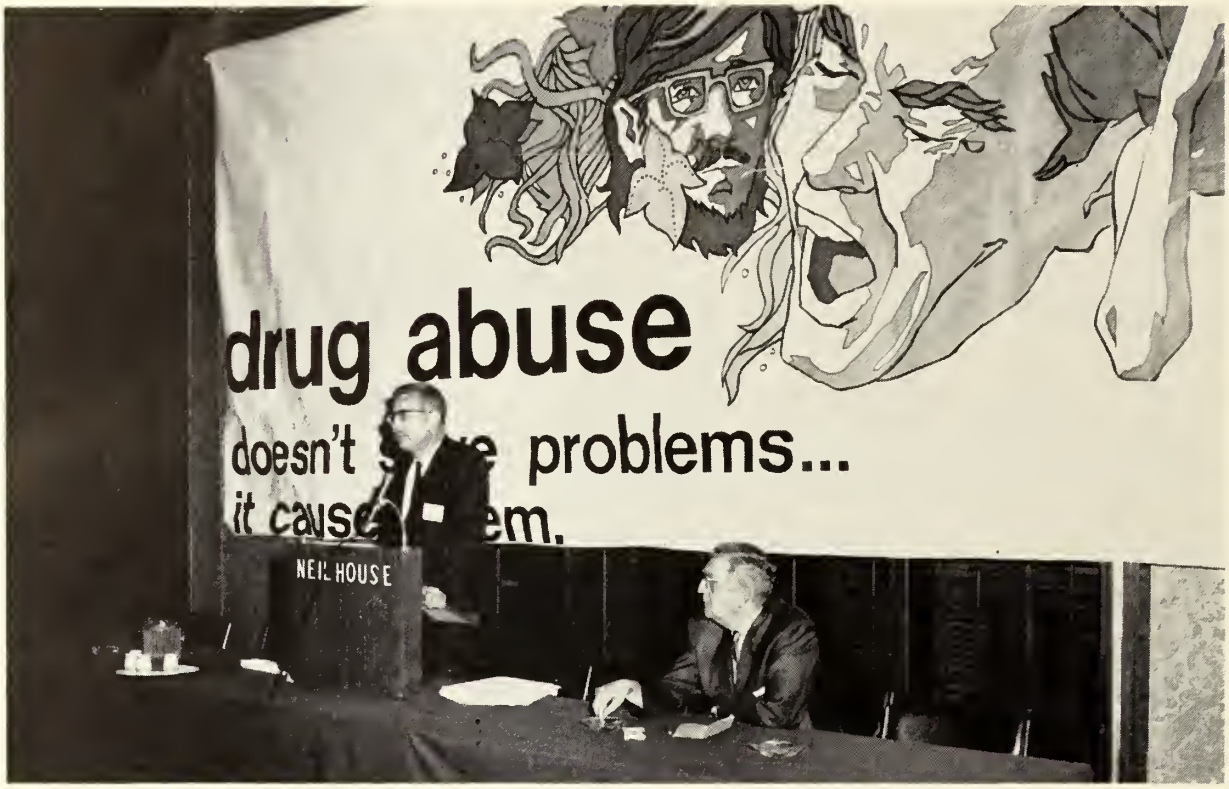
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Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

Attention on Drugs and the Younger Generation



One of the principal speakers at the drug conference was William R. Martin, M. D., chief of the National Institute of Mental Health Addiction Research Center, shown at rostrum. Seated is Wendell A. Butcher, M. D., conference chairman.

Conference Includes Educators; Others Who Deal with Youths

More than 250 Ohio physicians, elementary, junior high, high school, and college educators attended a conference on "Youth and Drugs — Use and Abuse," cosponsored by the Ohio State Medical Association in Columbus on October 13-14.

Other sponsors of the conference included the Ohio Academy of General Practice, Ohio Psychiatric Association, Ohio Department of Mental Hygiene and Correction, and the Ohio Education Association.

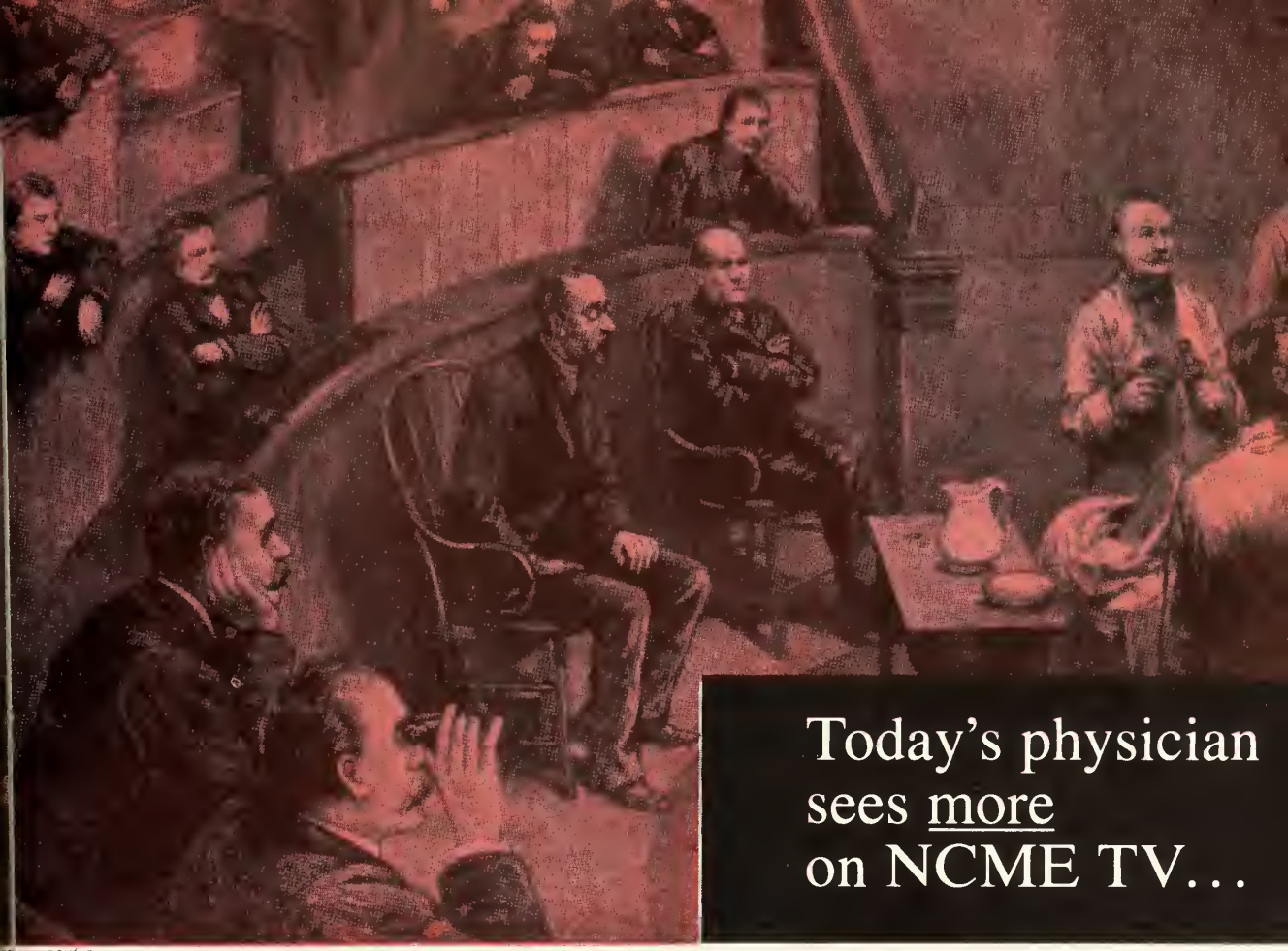
The conference stressed the medical, legal, educational, psychological and psychiatric problems facing young people who use the "soft" narcotics including marijuana, LSD, and "speed." Each physician and educator received a special packet of material on drug abuse — designed especially for parents, teachers, and physicians—prepared and distributed by the American Medical Association.

Speakers included Ohio Supreme Court Justice C. William O'Neill, Margaret J. Forsythe, M.A., Ed. D., dean of women at Ohio Wesleyan University, Delaware; William R. Martin, M.D., chief, National Institute of Mental Health Addiction Research Center, Lexington, Kentucky; Albert Sattin, M. D., senior instructor in psychiatry and research associate in pharmacology, Case Western Reserve University, Cleveland; and Humphry Osmond, MRCP, DPM, director, Bureau of Research in Neurology and Psychiatry, New Jersey Neuropsychiatric Institute, Princeton, New Jersey.

Victor M. Victoroff, M.D., of Cleveland, past president of the Ohio Psychiatric Association and current member of the OSMA Committee on Mental Health, moderated a panel discussion and question-and-answer period following all talks.

Overall conference chairman was Wendell A. Butcher, M.D., chairman of the OSMA Committee on Mental Health. The conference planning committee included Milton M. Parker, M.D., of Columbus; Viola V. Startzman, M.D., Wooster, and Richard G. Griffin, M.D., Worthington, all members of the Committee on Mental Health. Drs. Butcher, Parker, Griffin, and Victoroff also served as resource psychiatrists during discussion periods, along with the following representatives of the Ohio Psychiatric Association:

Norman S. Brandes, M.D., Jaime Smith e Incas, M.D., C. Eric Johnston, M.D., Walter Knopp, M.D., Josip Raulj, M. D., Robert E. Stevenson, M. D., and William E. Todd, M.D., all of Columbus.



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☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

Annual Roundup on Federal, State, and Local Taxes for Physicians

THE CLOSE OF ANOTHER YEAR and the beginning of a new one will find most taxpayers faced with the prospects of filing reports and making payments under several categories of federal, state, and perhaps local tax laws. This article is presented to furnish at least basic information on tax structures, deadlines for filing, forms to be completed, and potential liability of taxpayers under each classification.

Only general data can be given in an article of this nature. For specific information on individual tax liability, the taxpayer is advised to consult authentic tax manuals, seek the advice of authorized tax experts, or call upon personnel of respective taxing agencies. A tax expert can point the way to many advantages under various tax laws as well as guide the taxpayer away from embarrassing or perhaps costly errors.

The following tax categories are discussed in this article under respective headings:

(1) Federal Income Tax, including payroll deductions.

(2) The Federal Social Security program, including liability of physicians as employees or as self-employed persons, withholdings from employees' wages, etc.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash, and accounts receivable.

(4) Ohio Workmen's Compensation Tax, required of those with three or more employees (optional for those with one or two) and the Disabled Workmen's Relief Fund Tax.

(5) Ohio Sales and Use Tax.

(6) Ohio and Federal Unemployment Insurance Taxes.

(7) Municipal Payroll Tax, applying to residents of cities or villages which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discusson of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

FEDERAL INCOME TAX

Procedures for reporting income and paying federal income taxes for 1968 are based on a number of statutes and regulations dating back to the Internal Revenue Act of 1954. Revisions were incorporated in the Revenue Act of 1962, the Revenue Act of 1964, the Social Security Amendments Act of 1965, the Social Security Amendments of 1967, the Revenue and Expenditure Control Act of 1968, plus certain Treasury Department regulations issued under authority of those provisions.

New Income Tax Surcharge

The Revenue and Expenditure Control Act of 1968 incorporates a 10 per cent per annum surcharge on individual income taxes, effective from April 1, 1968. The surcharge is slated to expire July 1, 1969, unless Congress takes further action.

Since the tax is effective for nine months of 1968, the taxpayer adds 7.5 per cent to his computed 1968 tax. In estimating 1969 income tax, the taxpayer will add 5.0 per cent to his computed tax for that year. Certain alternative methods of calculating the tax are authorized.

Who Must File

Every citizen or resident of the United States must file an income tax return if the gross income for the year was $600 or more for the person under age 65, or $1200 for the person age 65 or over.

A self-employed person must file a return if his income from self-employment is $400 or more.

Forms and Payments

There are two types of returns, Form 1040A, and Form 1040.

Form 1040A may be used if the income was less than $10,000 and consisted entirely of wages reported on Withholding Statements for such wages and not more than $200 total of other wages, interest, and dividends (excluding $100 of dividends). When this form is used, if the income was under $5,000, the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund. If the income was between $5,000 and $10,000 the taxpayer must compute his own tax.

Form 1040 is used if the income is less than $10,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Form 1040 must be used if the income was more than $10,000. Separate schedules, in addition to

Form 1040, are provided for reporting business and professional income, capital transactions and other income. They are Schedules C, D, and B.

Form 2106 may be used to support travel and transportation expenses.

Declaration of Estimated Tax

Virtually all physicians in private practice, and other persons who have income from sources other than wages subject to withholdings, are required to file declarations of estimated income tax, and to make periodic payments on estimated tax.

Regulations issued under authority of the Social Security Amendments of 1965 require self-employed persons to include their self-employment social security tax in their declaration of estimated tax.

Specifically, every citizen or resident of the U. S. is required to make a declaration if his total estimated tax exceeds his withholdings (if any) by $40 or more; and

(a) He can reasonably expect gross income exceeding —

(1) $10,000 for a head of a household or a widow or widower entitled to the special tax rates;

(2) $5,000 for other single individuals;

(3) $5,000 for a married individual not entitled to file a joint declaration;

(4) $5,000 for a married individual entitled to file a joint declaration, and the combined income of both husband and wife can reasonably be expected to exceed $10,000; or

(b) He can reasonably expect to receive more than $200 from sources other than wages subject to withholdings.

The final quarterly declaration for 1968 taxes is due January 15, 1969.

A single declaration may be made on form 1040-ES on or before April 15, 1969, for the 1969 taxable year, or, quarterly declarations may be made on or before April 15, June 15, September 15, 1969, and January 15, 1970.

The estimated tax may be paid in full with the declaration on or before April 15, or quarterly on the dates indicated above. The estimate must be within 80 per cent of actual tax to avoid a penalty for most taxpayers. Amended declarations should be filed if the estimated income changes substantially.

Husband and wife may file separate declarations and a joint final return, or may file a joint declaration and separate final returns.

As indicated previously, in estimating tax liability, the taxpayer adds 7.5 per cent surcharge to 1968 computed tax, and 5.0 per cent to 1969 computed tax.

Exemptions and Allowances

An exemption of $600 may be claimed by the taxpayer for himself. He may also claim an exemption of $600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over a half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than $600 for the year. A child may earn $600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of $600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

Averaging Income

Certain taxpayers who have experienced a substantial increase in income for the year may find it to their advantage to average earnings over a five-year period. Averaging may apply to income from salary, dividends, interest, short-term capital gains, rental income, and business, and professional income. It does not apply to long-term capital gains, gambling winnings, and certain gifts and inheritances. Schedule G is used for income averaging.

Income-Splitting

Most married physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

An unmarried widower (or widow) who maintains a home for his dependent children is allowed to use joint return rates in the two years following death of spouse.

Adjusted Gross Income

For the person on salary, the total salary plus amounts received from interest, dividends, rent or from other sources constitutes the gross adjusted income.

The physician in private practice arrives at his adjusted gross income by adding to his cash receipts, interest, dividends, rent, etc., and deducting all items

no gag



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DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

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Each teaspoonful (5 ml.) of DIA-quel Liquid contains:

Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)

To reduce hypermotility and frequency.

Homatropine Methylbromide... 0.15 mg.

A safe dose for mild spasmolysis to curb cramping and griping.

Pectin... 24. mg.

Demulcent, adsorbent. Helps form stools.

Alcohol 10% by volume.

...case you're curious, back in the 1700's paregoric was ...g used for diarrhea, but since the state of the pharma...tical art was extremely primitive, fungus growth in ... medication was a problem. Bitter-tasting camphor ... added to prevent such growth and anise oil was ...ed in an attempt to cover up the camphor taste. ...-quel Liquid is a modern formulation that does not ...tain either of these outdated ingredients.

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of expenditure necessary in earning his income. (In place of cash receipts, he may include total charges if he uses accrual method of reporting income.)

Following are the more important items that may be considered for deduction.

Deductible Business Expenses

Office Rent — Rent paid to another person for office space may be deducted. That portion of rent paid for the office in a combined office-home may be deducted on a pro-rata basis of space used. If the physician owns his own home-office combination, he may not deduct rent, but may claim depreciation on that portion used as an office, again on a pro-rata basis.

Automobile — Prorated cost of an automobile used for professional purposes may be deducted, the proportion of deduction based primarily on mileage. It is unlikely that a physician could claim, to the satisfaction of IRS, full deduction on an automobile even though he may maintain one car for professional purposes and another for family use. The matter of commuting from home to office comes into the picture, as does personal, social, and family use of the car. A discussion of this topic appeared in the July 22, 1968, issue of *The Journal of the American Medical Association,* as part of a feature sponsored by the AMA Law Department. The cost of an automobile includes expenses for repair, upkeep, gasoline, service, etc.

Depreciation may be deducted on an automobile used in professional business. Annual depreciation may be deducted on the basis of cost, less trade-in value, divided by the number of years the taxpayer uses the vehicle. The physician should seek the advice of a tax expert as to whether the "declining-balance method" of depreciation would be advantageous to him.

Damage to an automobile used in professional work, not done through negligence, and not covered by insurance, is a deductible item.

Under specified conditions the taxpayer may choose to deduct a flat allowance based on mileage accumulation. The allowance, if the taxpayer is eligible, is 10 cents per mile for the first 15,000 miles and 7 cents for additional miles of business travel.

Other Transportation Cost — Deductible items include sums paid for taxi fare and other transportation for professional purposes, salary of a chauffeur whose duties relate to professional calls, etc.

Professional Dues and Publications — Dues paid to professional associations to which the physician belongs, in the interest of his profession, are deductible. Publications purchased in the interest of his professional work become deductible items, as do publications purchased for the waiting room.

Refresher Courses — The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Section 1.162-5 of the IRS regulations).

Deductions may be made for "refresher" type courses, or those attended to maintain the skills of the physician and to keep him abreast of developments in his field of practice. Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

Travel Expenses — The Revenue Act of 1962 deals extensively with travel expenses. Emphasis is placed on the distinction between travel time and expenses devoted to business or professional purposes and that used for vacation or entertainment. Regulations are less restrictive for the taxpayers if the trip does not exceed a week or if personal or vacation time does not exceed 25 per cent of the total time of the trip. Expenses for personal activities such as sightseeing, social visiting, personal entertaining, or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone.

Records should indicate a distinction between travel expenses, transportation expenses, and business entertainment expenses while traveling. Meals and lodging may not be deductible if the trip is no longer than a working day or the stay is not overnight.

Entertainment Expenses — Section 4 of the Revenue Act of 1962, or Public Law 87-834, requires the taxpayer to show proof and degree of business relationship for the Federal income tax treatment of certain business travel, gift, and entertainment expenses.

In general, a physician may deduct on his Federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service by appropriate evidence that such expenses are ordinary and necessary business expenses and clearly related to the production of business or professional income.

Exact records on each item are important. Here are criteria that may be used to determine the deductibility of entertainment expenses:

Specific purpose of entertainment; nature of the doctor's practice; period of time in practice; number of patients he already has; percentage of patients received as referrals; names of individuals entertained and reason why additional income could reasonably be expected from each; whether or not referrals were actually received from doctors entertained and any indication of the effect of the entertainment on these referrals; number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive; whether

or not other doctors in the same type of practice in the locality have entertainment expenses.

Depreciation — Important principles in regard to claiming depreciation are contained in Treasury Department Publication No. 456, entitled *Depreciation, Guidelines and Rules,* revised August, 1964.

Depreciation may be claimed on virtually all equipment and furnishings of more or less permanent value used in practice; also on buildings used for business or professional purposes.

If the taxpayer is unfamiliar with methods of claiming depreciation, he may wish to consult a tax expert as to which method would be to his advantage — straight line, declining balance, or sum-of-the-digits method.

Insurance Premiums — Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Premiums paid for disability insurance are deductible only if the policy specifies that benefits are for business or overhead expenses.

Other Business Expenses — Salaries of all persons whose duties are connected with professional work, and the employer's share on Social Security and other payments made in behalf of employees; items consumed-in-the-using such as medicines, bandages, laboratory supplies, etc.; uniforms or other garments used in professional work but not suitable for street wear; cost of telephones, telegraph, heat, light, water, etc.; Ohio and Federal gasoline tax, if this has not been included in cost of gasoline; interest on business indebtedness; cost of replacement or repair of professional equipment lost or damaged by fire, theft, etc., not covered by insurance; certain legal expenses, etc.

Investment Credit

As much as 7 per cent credit applies to cost of qualified business property placed in service in 1968 with a useful life of at least eight years. Properties with useful lives of between four and eight years qualify for reduced credits. No credit is allowed on property with less than four years of useful life.

For property purchased before 1968, consideration should be given to the suspension period which began on October 10, 1966, and ended December 31, 1967. A taxpayer who purchased property during that period could select to exempt from suspension of investment credit up to $20,000.

The taxpayer who feels that this credit is involved in determining his taxes would do well to obtain expert advice. The credit is figured on Form 3468.

Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, providing that there is not a duplication of deductions under the two categories.

Medical, Dental, and Drug Expenses — Deductible items under these headings include the cost of diagnosis, care, mitigation, treatment or prevention of disease or any treatment that affects a part or function of the body; also costs of transportation primarily for or essential to medical care and cost of travel prescribed for relief of specific ailments; costs of medical and hospital insurance; cost of drugs whether or not prescribed (but not toiletries and sundries); vitamins and supplements if prescribed. (Cost of special foods and beverages is not deductible as medical expense if taken as substitutes for normal food and drink.)

Maximum ceilings on medical deductions no longer apply.

Fifty per cent of the premium paid for medical care policies, including Medicare Part B payments, are deductible up to $150. The remaining balance is deductible as ordinary medical care expense.

The taxpayer may deduct under this category for himself, his wife, and his dependents expenses which exceed 3 per cent of adjusted gross income, on condition that the amount of deductions for drugs is in excess of 1 per cent of adjusted gross income.

Deductions may not be claimed for medical expenses reimbursed by insurance.

Contributions, Gifts, etc. — Deductions up to 30 per cent may be claimed for contributions for religious, charitable, scientific, literary, educational, and similar purposes, including contributions to governmental agencies through which the gift is made for public purposes. Travel in behalf of volunteer charitable work is deductible at five cents a mile.

Under certain provisions, gifts above the 30 per cent ceiling may be carried over for as much as a five-year period.

Donations to private foundations remain under the 20 per cent ceiling, with certain exceptions. Still not eligible for deductions are gifts to candidates for public office, political parties, organizations seeking to benefit a particular group, organizations where there is a profit motive, subversive groups, organizations which attempt to influence legislation or engage in propaganda, etc. Gifts to fraternal or professional organizations are eligible for deductions only when the contribution goes to a special group set up within the organization for charitable, educational, or other approved purposes.

Interest — The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes — Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, and state gasoline taxes.

The following state and local taxes may be deducted: Auto plate and driver license fees, cigarette and tobacco taxes, alcoholic beverage taxes, admission, occupancy, and transfer taxes.

Casualty Losses and Thefts — The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, provided the amount is in excess of $100 for each loss and provided the amount is not claimed as a business deduction and not covered by insurance.

Retirement Income

Pensions and annuity payments received by individuals fall into three classes for federal income tax purposes; Nontaxable, fully taxable, or partly taxable. Certain items of retirement income also may be subject to credit, allowances varying according to whether the retired person is under age 65, over that age, or over age 72. A person who is receiving retirement income, therefore, would do well to check with an office of the Internal Revenue Service, or consult a tax expert.

Standard Deduction

In lieu of listing amounts paid for nonbusiness deductible items, under the Revenue Act of 1964, the taxpayer may elect to use the 10 per cent standard deduction, or the minimum standard deduction. However, both husband and wife must use the same method. The minimum standard deduction is computed as follows: $200 ($100 if married and filing separate returns) plus $100 for each exemption claimed on Schedule A, of the return, including exemptions for age and blindness. The deduction is limited to $1,000 ($500 if married and filing a separate return). Consideration should be given to this provision in determining the amount to be entered on line 2 of the Tax Computation Schedule on page 2 of Form 1040-ES.

Other Provisions

Dividends paid out of a corporation's current or accumulated earnings are taxable. The first $100 of such dividends are tax-free when the taxpayer takes the dividend exclusion. On a joint return the exclusion may be up to $200.

An individual who is 65 or older may exclude from gross income, any capital gain attributable to the first $20,000 of the sales price of his personal residence. Provided the property has been owned and used by him as his principal residence for at least 5 years during the 8-year period preceding the sale.

The taxpayer who, because of employment, must engage a sitter for a child up to age 13, or for a physically or mentally defective dependent, may qualify for deductions on expenses for this purpose.

Partnerships

The partnership itself is not subject to income tax, but is required to file an information return, Form 1065. Tax liability falls upon the individual partners. Simple agreements for the sharing of expenses, co-ownership and maintenance of property, and the like, are not considered partnerships, unless a profit element also is involved.

Where an actual partnership exists, partners would do well to seek expert advice in regard to tax liability. An Opinion of the Ohio Attorney General given in 1961 permits professional men to associate as partnerships under Ohio limited partnership law and thus make themselves eligible for favorable tax action under the U. S. Internal Revenue Act.

Professional Corporations

In 1961, the Ohio Legislature enacted Sections 1785.01 through 1785.08 of the Ohio Revised Code, authorizing members of certain professions, including physicians, to form professional associations. A number of other states have enacted similar legislation. One of the primary purposes of the legislation was to make it possible for associations of professional persons to be treated as corporations for federal tax purposes.

A number of such professional associations have been incorporated under Ohio law, and have made application to IRS for special tax benefits. The Ohio State Medical Association has gone on record requesting the Internal Revenue Service to take no unfavorable action that would change regulations in regard to tax treatment of professional associations.

The U. S. District Court recently ruled in favor of a Cleveland based group of physicians, entitling the organization to the tax advantages of a corporation under existing laws. But at latest report of the IRS U. S. District Courts in Florida and Georgia have also upheld the rights of professional corporations, stating that certain Treasury Regulations under Sec. 301.7701 are invalid. But at latest report the IRS was still maintaining its former position for associations other than those on which the courts ruled.

Retirement Programs for Self-Employed

Beginning in 1968, the 50 per cent limitation on deductible contributions to retirement programs for self-employed persons is lifted.

The Self-Employed Individuals Tax Retirement Act, better known as the Keogh Act, was enacted in 1962. H. R. 13103, signed by the President late in 1966, doubled the tax deduction benefits available under the act, **effective in 1968,** and offers certain other advantages.

Physicians who are contemplating establishing retirement programs, or revamping present plans, would do well to investigate the advantages and perhaps disadvantages of programs under this act. Any such program must apply to employees under specified conditions as well as to the self-employed individual.

District Office and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are two districts in Ohio. Counties comprising each district follow:

For the Cincinnati District — Director of Internal Revenue, Cincinnati, Ohio 45202, comprising the following counties: Adams, Athens, Brown, Butler, Clark, Clermont, Coshocton, Clinton, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hamilton, Highland, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Miami, Montgomery, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Preble, Ross, Scioto, Union, Vinton, Warren, and Washington.

For the Cleveland District — Director of Internal Revenue, Cleveland, Ohio 44113; comprising the following counties: Allen, Ashland, Ashtabula, Auglaize, Belmont, Carroll, Champaign, Columbiana, Crawford, Cuyahoga, Darke, Defiance, Erie, Fulton, Geauga, Hancock, Hardin, Harrison, Henry, Holmes, Huron, Jefferson, Lake, Logan, Lorain, Lucas, Mahoning, Medina, Mercer, Monroe, Ottawa, Paulding, Portage, Putnam, Richland, Sandusky, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Wayne, Williams, Wood, and Wyandot.

Claims for refunds are mailed to the District Director of Internal Revenue, Cincinnati, Ohio 45298.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

Income taxes are not withheld for domestic servants, agricultural workers, and certain other persons to whom wages are paid.

Withholdings do not apply to the self-employed person's income since he pays through the estimated tax procedure.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

A new edition of *Circular E, Employer's Tax Guide* (revised May 1, 1968) has been issued. This revised edition incorporates a prorated portion of the 10 per cent surcharge for payroll withholding purposes. It also gives withholding tables for Social Security deductions.

The employee who has reason to believe that his withholdings will not cover his tax liability may elect to claim fewer exemptions than he is entitled to, or request the employer to withhold an additional amount.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, for the calendar quarter, during the month immediately following the quarter for which deductions are made. Social Security taxes withheld from employees' wages and the employer's matching contributions are reported on this same form. Self-employment social security taxes are not reported on this form.

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

Deposit of Withholdings

An employer who withholds as much as $100 per month for the purposes of income tax liability and F.I.C.A. liability (employer's and employee's shares) shall take these funds with Form 501 to any commercial bank qualified to receive such deposits. The deposit portion of the form serves as a basis for crediting the taxpayer's account identified by the Employer's Identification Number. The stub portion of the form is retained by the taxpayer as a record of his deposit.

Report of Funds Paid

Payments made during the year for interest of $10 or more, rents, or commissions, not subject to withholdings of $600 or more and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on

or before February 28 of the following year to the Director, Internal Revenue Service Center, 222 East Central Parkway, Cincinnati, Ohio 45202. Sec. 6652 provides penalties for failure to file these statements.

SOCIAL SECURITY TAXES

The Social Security Amendments of 1967 set the base on which social security taxes are paid for 1968 at the first $7,800 of earnings. The rate of tax for the year 1968 for self-employed persons is 6.4 per cent. This figure is the sum of 5.8 per cent for OASDI (old-age, survivors, and disability insurance), and 0.6 per cent for HI (health insurance).

Beginning January 1, 1969 the rate of tax for self-employed persons will be 6.9 per cent.

The social security tax on self-employment earnings is to be paid quarterly with the Declaration of Estimated Tax (Form 1040ES).

The physician who has a part-time salaried position through which social security taxes are withheld need not pay the self-employment tax if social security taxes are withheld on income up to $7,800. If the salary subject to withholdings is less than $7,800, he must pay self-employment tax on the difference between the maximum and his salary.

Federal Health Insurance Programs

The Medicare program is in two parts: (1) hospital insurance, and (2) medical insurance.

Persons who are approaching age 65 and wish to take advantage of the hospital insurance program should notify the Social Security office at least a month before reaching age 65. Retirement is not a factor in eligibility for either the hospital insurance or the medical insurance programs.

Persons aged 65 and over are eligible for benefits under the medical program provided that they enroll during a specified enrollment period and agree to pay $4 a month into the medical program fund.

Provisions for becoming eligible for benefits under the Medicare program were modified considerably by the Social Security Amendments of 1967, which became law late in 1967. Doctors of medicine were specifically excluded from the Social Security program until 1965 (unless previously covered under a salaried position or military service). Therefore, a physician who is in doubt as to his eligibility should consult his local Social Security officials.

Benefits under the medical program are for the individual enrollee only. The spouse who is aged 65 must enroll also if benefits are desired for both husband and wife.

Social Security for Employees

As employers, physicians will be interested in the following provisions of the law:

Every employer of one or more employees is required by law to deduct social security taxes from the employee's wages and to contribute a matching amount himself.

For 1968 the rate is 4.4 per cent each for the employee and the employer, with deductions made on the first $7,800 of wages. This amount includes 0.6 per cent for the health insurance program.

Beginning January 1, 1969 the amount of withholding is 4.8 per cent from the employee's wages up to $7,800, with a matching amount contributed by the employer.

The tax return and the informational return combined in one report is to be filed quarterly during the month after the quarter ends.

Employees Receiving Benefits

For the benefit of physicians who employ persons now receiving social security benefits, the following information is presented:

A worker under age 72 who is receiving benefits under the social security program will not lose any payments unless he makes more than $1,680 in a year. If he makes more than that amount certain deductions apply to his benefits. A person over age 72 may earn any amount and not lose benefits.

Both men and women may elect to receive benefits after age 62 at somewhat reduced rates. The widow of an insured worker may elect to receive benefits after age 60 at reduced rates.

A disabled worker whose disability is expected to last for at least 12 months may qualify for disability benefits beginning with the seventh month of disability. The Social Security Amendments Act of 1965 liberalized the requirements affecting people who are disabled by blindness.

Benefits to a child who is eligible to receive such benefits continues through age 21, if the child is a full-time student in an accredited school. If the child is not a full-time student, benefits continue to the 18th birthday.

Not covered for social security purposes is work done by a child under 21 for his parent, by a husband for his wife, or by a wife for her husband. This applies also to foster or step-relationships. Services performed by or for "in-laws" and relatives other than those named are covered, provided a genuine employment relationship exists.

Under current provisions, work that a parent does for a son or daughter in the course of a trade or business is covered by Social Security. However, work done in the household of a son or daughter is not covered.

Domestic workers in private homes who receive wages of at least $50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns $50 or more in a

quarter (approximately $3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns $150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer on 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

In Section 5739.01, under the definition "vendor," the Revised Code states: "Physicians, dentists, hospitals, and veterinarians who are engaged in selling tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, are vendors.

Under the definition of "consumer," the Code states: "Physicians, dentists, hospitals, and blood banks operated by nonprofit institutions and persons licensed to practice veterinary medicine, surgery, and dentistry are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital or blood bank service or the practice of veterinary medicine, surgery, and dentistry."

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax, and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Ohio Department of Taxation, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014. "The Quarterly Consumers Return."

The Sales and Use Tax is a bracket tax with a minimum rate of 4 per cent.

Forms are routinely sent to physicians on record who have been assigned a Consumer's Use Tax account number. Physicians who have not been assigned an account number should write to the Ohio Department of Taxation in Columbus.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 30 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

For individuals and partnerships, Forms 910 and 911 are filed between February 15 and April 30 with the County Auditor of each county where personal property is held.

For corporations, Forms 930 and 931 are filed with the County Auditor between February 15 and April 30 if personal property is held in only one county. Forms 945 and 931 are filed with the Ohio Department of Taxation if personal property is held in more than one county, also due between February 15 and April 30. Separate bills will be received from the County Treasurer for tangible personal property and from the Treasurer of the State for intangible personal property.

Certain changes have been written into the law in regard to some assessment valuation and rates, but these changes will be reflected in the new tax forms distributed for the current tax period. Rather extensive changes have been made in regard to farms and farm property. Personal property used in agriculture will be fully exempt from personal property taxation in 1963. The return forms reflect a reducing percentage of taxability in the interim years.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its true value. Counting the year of purchase as a half year, a depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 2½ per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

It should also be noted that personal investments such as corporation stocks, notes or mortgages, etc., are also taxable and must be returned in the personal property tax report along with business property.

When a physician opens his practice (or a person starts in business) during the calendar year, he is required by law within 90 days of time of opening to list all of his taxable property, as of the date he engaged in practice. The valuation of all taxable property to be returned for taxation is determined by multiplying the value by the number of full months in the year and dividing the result by 12.

Forms 937 and 902, obtained from the County Auditor, must be filed with the Personal Property Tax return to obtain a lesser value than book value.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually, or the last day of the fiscal year.

As defined in Section 5701.07 R.C., credits mean "the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

It should be understood that there is no discrimination in the foregoing provisions against physicians. Every person who possesses intangible assets, such as accounts receivable, or any business or professional man who does business on a credit basis, must return his accounts receivable for taxation.

UNEMPLOYMENT TAX

Physicians or other employers who have **three or more** employees, including other physicians, nurses, receptionists, technicians, office workers, etc. are subject to the Ohio Unemployment Compensation Tax. Those who have four or more are liable also for the Federal Unemployment Insurance Tax.

In professional associations incorporated under Ohio S. B. 550, members of the group are counted as employees.

Ohio Unemployment Compensation Tax

In general, employment of **three or more persons** renders the employer liable for this tax. Excluded from the number of employees is a minor who does short-time work but whose principal occupation is that of student, and a person doing casual labor not in the course of the employer's regular business or profession. Careful consideration should be given to an extra worker as to whether he should be included as an employee or as an independent contractor. A cleaning woman, for example, who works only a few hours a week, but who comes in regularly, would probably be classed as an employee. A physician who is in doubt as to his liability should request clarification from the Ohio Bureau of Employment Services, 145 South Front St., Columbus, Ohio 43216; phone 469-2579.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This form also shows how the rate was calculated.

Rates for 1969, will be further reduced from those currently in effect, reflecting the improved employment picture in Ohio. The emergency rate assessment is no longer necessary and any 1969 rates will range from zero to a maximum of 4.0 per cent.

While employers with a zero rate will have no tax to pay in 1968, they are required to furnish the quarterly contributions report the same as all other employers.

Only the first $3,000 paid by any employer to any one individual "in employment" within a calendar year is taxable.

Penalties are specified in the Ohio Code for failure to comply with provisions of the law.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the bureau will request separation and wage information from the employer. These forms should be returned within seven days of receipt.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing **three or more** employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees

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he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of **less than three** employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by August 1 for the first half of the year, and by February 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus.

Disabled Workmen's Relief Fund

Effective in 1959, the Ohio General Assembly increased permanent and total disability benefits and enacted Senate Bill No. 472 to finance this increase by levy of an excise tax on employers of 3 cents per $100 of total aggregate gross payroll. This excise tax applies to employers of three or more employees, and to employers of less than three persons who have voluntarily subscribed to the Workmen's Compensation Insurance Fund; also self-insured employers. Report for the calendar year with premium is due by March 1 of the following year.

Federal Unemployment Tax

The Federal Unemployment Insurance Tax applies to employers who have **four or more persons** on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year.

The tax is on the first $3,000 paid to an employee. A considerable credit is allowed on all payrolls which are reported to the state unemployment compensation agency, and on which the tax is paid (see under Ohio Unemployment Compensation Tax.) If an employer has paid his state unemployment tax in full, the federal tax is reduced to a minimum.

CITY PAYROLL TAXES

Many municipalities in Ohio have enacted laws imposing income taxes on wage earners and placing the primary responsibility on the employer to make payroll deductions, file forms, and pay taxes to the city government. This responsibility falls upon a self-employed person, such as a physician in private practice.

Laws vary as to liability of a person who earns the major part of his income in one community and resides in another. The physician who moves into a new location would do well to inquire as to local tax laws.

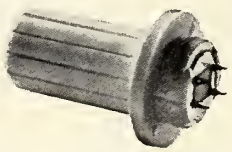
Dr. Samuel J. Webster, Cleveland, was the subject of a feature article in the *Plain Dealer* over the heading "Physician 93 Closing Office." He has been in the practice of medicine for 72 years, having graduated from Western Reserve University School of Medicine in 1896.

Average age of the 14.8 million World War II veterans is 48.3 years. Ages of the 26 million U. S. veterans range from below 20 to over 100. Average age is 44.2 years. Ohio is one of seven states with more than a million veterans. — Veterans Administration.

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The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.



To headache, a sovereign remedy was
to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. Co.' narcotic products are Class B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



Louie lost weeks with acute shoulder bursitis. That's a l
of pain, stiffness and tenderness...and also a lot of fis
It might have been different with **ıtazolidin® alk**
phenylbutazone
dried aluminum hydroxide gel
magnesium trisilicate

If it doesn't wor a week, forget

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-B

For complete details,
please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

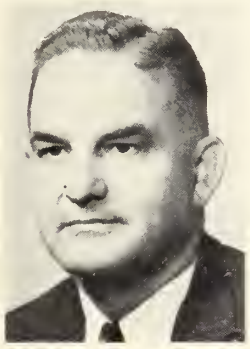
Lederle

350-8

Executive Secretary Is Named for State Medical Board of Ohio

Dr. Mervin F. Steves, Cincinnati, has been appointed Executive Secretary of the State Medical Board of Ohio to fill the vacancy left when Dr. W. Thomas Washam resigned from that post and returned to private practice.

The State Medical Board is the State agency charged with the responsibility of licensing physicians and limited practitioners in Ohio and enforcing the law as it applies to the healing arts. Dr. Steves is thoroughly familiar with the workings of the Board, having served six years as a member of the Board under appointment by the Governor.



Dr. Steves

A native of Cincinnati, Dr. Steves attended public schools there as well as the University of Cincinnati. He received his medical degree from the University of Cincinnati College of Medicine in 1938. Internship and medical residency followed at Christ Hospital where he later became chief resident. A tour with the U. S. Public Health Service as special consultant assigned to the Chicago Health Department's Intensive Treatment Center ended in 1944. In that same year he returned to Cincinnati and entered the private practice of internal medicine, in which capacity he has served to the present time.

Professional appointments include those as staff member of the Christ Hospital for many years, medical director of the Department of Physical Medicine, and personnel physician from 1944 to 1960, also at Christ Hospital. Dr. Steves is in process of phasing out his practice in Cincinnati in order to devote his time to his new responsibilities with the Board.

He is a member of the Academy of Medicine of Cincinnati, the Ohio State Medical Association, the American Medical Association, American Congress of Physical Medicine and Rehabilitation, and the American Heart Association.

Other affiliations are with Alpha Chi Sigma and Phi Chi, chemical and medical fraternities, respectively, the Methodist Church, the Board of Trustees of the Methodist Home for the Aged in Cincinnati, and several Masonic bodies. Among Masonic honors, he is an officer in the Scottish Rite, medical director for the Shrine, a member of the Order of Jesters, and a member of the DeMolay Legion of Honor. Dr. Steves is married to Viola G. Predmore, formerly of Rushsylvania, Ohio, and has three children, the youngest age 18.

Applications Mailed for Biennial Registration of Ohio MDs

The State Medical Board of Ohio has mailed to Doctors of Medicine on record applications for the biennial registration required under the revised Medical Practice Act.

Specifically, Section 4731.281 of the Revised Code of Ohio states in part: "Every doctor of medicine licensed to practice medicine or surgery within this state shall, on or before the first day of January of each odd-numbered year, apply to the state medical board for a certificate of biennial registration with the board upon an application which shall be furnished by the board, and shall pay at such time a fee of ten dollars to the board."

If for any reason a doctor has not received the application form, he should contact the board immediately. The address is as follows: State Medical Board, State of Ohio, 21 West Broad Street, Columbus 43215.

Application forms are due back in the board office by December 31. Attention is called to further provisions of the Medical Practice Act: "Failure of any certificate holder to register and comply with this section shall operate automatically to suspend his certificate to practice, and the continued practice after the suspension of the certificate to practice shall be considered as practicing without a license." A delinquent registration fee is specified for reinstatement of a suspended certificate to practice.

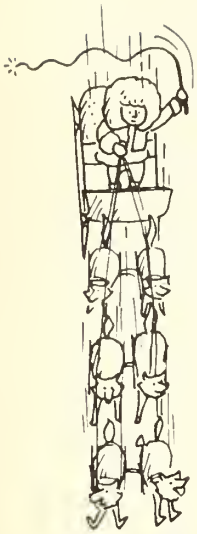
The biennial registration will enable the Board to control more effectively problems concerning transient physicians, provide statistical information as to the distribution of physicians and the various types of medical practice within the state.

A Doctor of Medicine who is retired from active practice, if he wishes to retain his license, must file the biennial registration form and pay the registration fee.

Each physician registered under these requirements will receive a printed list of persons so registered in Ohio. The list will be mailed as soon as practicable after the registration is completed.

Pre-Registratio

OSMA GOES MODERN – avoid long lines, last minute registration, fumbling for you credentials, etc. Fill out the enclosed registration form, mail to the OSMA office an we do the work for you. **HERE IS HOW IT WORKS** – after OSMA receives your pre registration form we will check membership, fill out your registration card. After th has been verified, we will put your badge, program and requested social functio tickets in an envelope in your name. Then all you have to do is come to the PRE REGISTRATION DESK ask for your envelope in your name and you are off to vis the exhibits, and attend the meetings of your choice. Make ONE STOP do it, you wi be glad you did!!!



PRE-REGISTRATION FORM

1969 Annual Meeting
Columbus, Ohio

Ohio State Medical Association
May 12-16, 1969

Name_____
(Please Print)

Address_____
(Number and Street) (City) (State)

I am:

- ☐ OSMA Member
- ☐ Official OSMA Delegate
- ☐ Official OSMA Alternate
- ☐ Non-member Physician
- ☐ Guest
- ☐ Medical Student
- ☐ Scientific Exhibitor
- ☐ Technical Exhibitor (representing_____Company)
- ☐ Executive Secretary
- ☐ News Media

Please prepare guest badge for my spouse

_____
(Please Print Name)

List your Field of Practice:_____

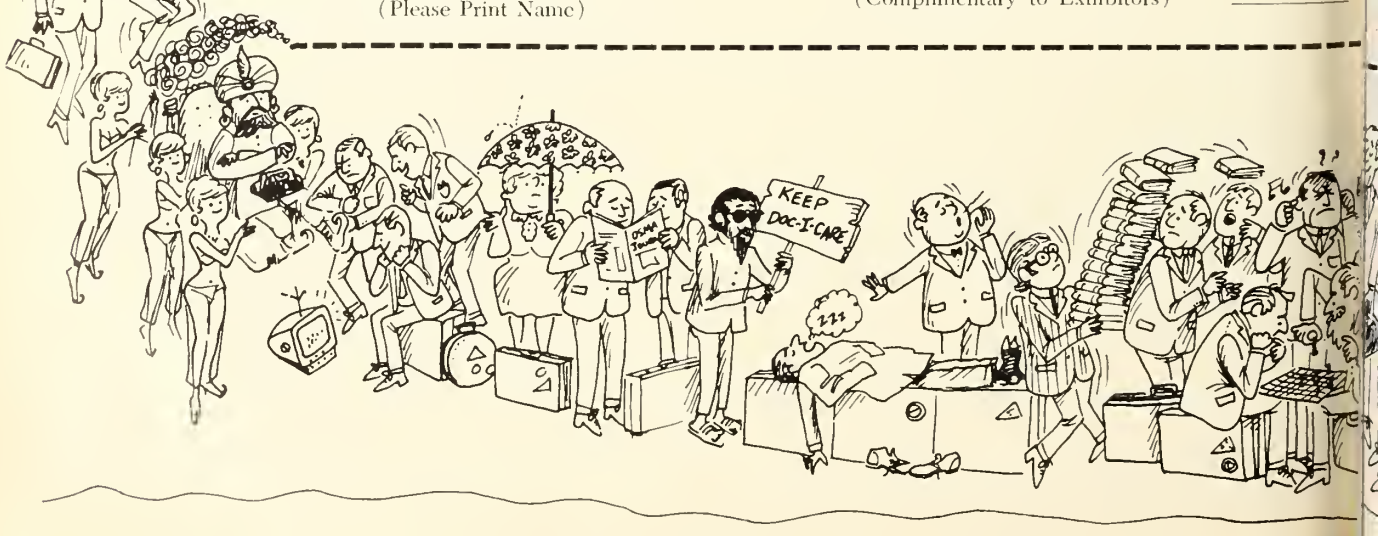
– SOCIAL FUNCTION TICKETS –
RESERVATIONS

Please indicate the number of persons for whom you want tickets:
Make checks payable to:
Ohio State Medical Association
Mail this form to:
Ohio State Medical Association
17 South High Street, Suite 500
Columbus, Ohio 43215

Wednesday, May 14, 1969 — 7:00 P.M. Number
"Hawaiian Luau"
Sheraton-Columbus Hotel
$10.00 per person _____

Thursday, May 15, 1969 — 12:00 Noon
"Exhibitors Luncheon"
Veterans Memorial Building
$4.00 per person
(Complimentary to Exhibitors) _____





nd Hotel Reservation

Make Your Hotel Reservations for the 1969 OSMA Annual Meeting

Columbus May 12-16

Leading Downtown Columbus Hotels at Prevailing Rates

Sheraton-Columbus Motor Hotel
50 North Third Street
(OSMA Headquarters)

Singles	$14.00-$18.00
Doubles	$19.00-$23.00
Twins	$19.00-$23.00

(Additional Charge for extra person — $4.00
Roll-a-way $4.00)

Holiday Inn — Downtown
175 East Town Street

Singles	$11.50
Twins	$17.00

Neil House Motor Hotel
41 South High Street

Singles	$10.00-$18.00
Doubles	$13.00-$19.00
Twins	$16.00-$26.00

Christopher Inn
300 East Broad Street
(Woman's Auxiliary Headquarters)

Singles	$13.00-$15.00
Doubles	$17.00
Twins	$19.00

Southern Hotel
South High and East Main Streets

Singles	$ 9.00-$10.50
Doubles	$12.50-$14.00
Twins	$12.50-$17.00

Pick-Fort Hayes Hotel
31 West Spring Street

Singles	$10.50
Doubles	$14.50
Twins	$14.50

All rates subject to change • If you plan to share a room, please indicate name of roommate

HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Columbus, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 12-16 (or for period indicated).

_____Single Room _____Twin Room

_____Double Room Other accommodations _____

Price Range _____

Arrival May _____ _____ at _____A.M. _____P.M.

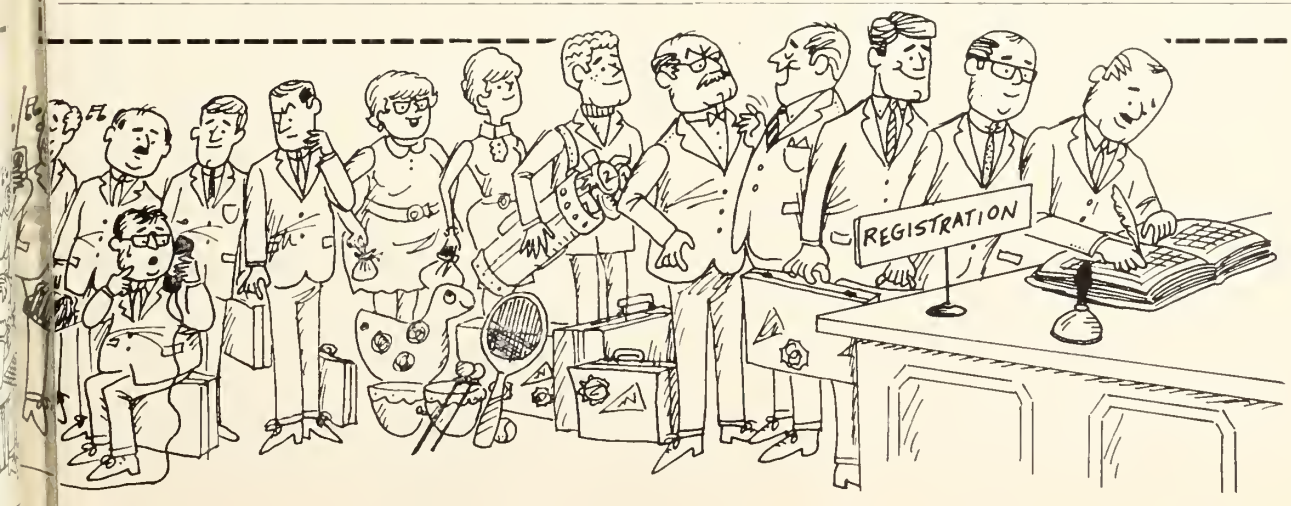
Departure May _____ at _____A.M. _____P.M.

PLEASE VERIFY MY RESERVATION

Name_____

Address_____

_____



Medical Assistants of Nation Meet in Ohio



Some principals in the Columbus annual meeting of the American Association of Medical Assistants are shown. *Lower table, from left: Doris Bell, trustee, Burlington, Vt.; Irving Pallin, M.D., advisor, Brooklyn, N.Y.; Marian Cooper, trustee, Pittsburgh, Pa.; John Wyatt Davis, Jr., M.D., Lynchburg, Va.; Mary Jane Michaels, trustee, Morganton, N.C.; Elisabeth Massey, trustee, San Diego, Calif.; Henry Bodner, M.D., advisor, Van Nuys, Calif.; Dorothy Ross, trustee, Baldwin, N.Y.; Travis Smith, M.D., advisor, Abilene, Tex.; and Gerry Schwarz, trustee, Oklahoma City, Okla.*

Upper table, from left: Eugene Capocasale, M.D., Zanesville; W. (Bill) Webb, Executive Secretary, Academy of Medicine of Columbus and Franklin County; Glenn E. Millard, M.D., former chairman of AAMA advisory committee; Lucille Swearingen, Bartlesville, Okla., parliamentarian; Betty Lou Willey, Port Huron, Mich., speaker of the House of Delegates; Elvera Fischer, Chicago; immediate past president; Ruth Dize, Norfolk, Va., vice-president; Dwight L. Wilbur, M.D., San Francisco, president of American Medical Association; and Margaret Swank, Newark, Ohio, 1967-1968 president of AAMA.

Ohioan Presides at the National Meeting of Medical Assistants

Ohio was host to the American Association of Medical Assistants, as the group met in Columbus, with Mrs. Margaret Swank, Newark, presiding as national president. This was the 12th annual convention of AAMS, with main features of the program extending from Wednesday, October 9 through Sunday, October 12, at the Sheraton Columbus Motor Hotel.

Mrs. Swank was installed as president of AAMA at the 11th annual convention in Los Angeles, October 11-13, 1967. She has been a medical assistant in Newark for more than 15 years and was one of the active participants in organizing the Ohio State Society of Medical Assistants and in the activities of the national organization.

Mrs. Mildred Crawford, San Antonio, Texas, was installed as the 1968-1969 president.

Other officers for 1968-69 are: Ruth Dize, president-elect, Norfolk, Va.; Marie Young, vice-president, Indianapolis, Ind.; Pauline Hunter, secretary-treasurer, Phoenix, Ariz.; Betty Lou Willey, speaker of the House of Delegates, Port Huron, Mich.; and June Franko, R.N., vice-speaker, Roswell, N.M.

In a luncheon address during the convention, Dwight L. Wilbur, M.D., San Francisco, President of the American Medical Association, reminded medical assistants of their roles as direct links between physicians and patients.

Dr. Wilbur told the more than 600 medical assistants and guests attending the convention that medical assistants "must concentrate more energy than ever before on seeing that each patient gets the best possible treatment as a human being." He added, "We physicians count on you very heavily to help us give our patients—and give the nation—the best medical and health care possible."

Among events was presentation of a $250 medical assistant scholarship to Susan Freeman, Cleveland, who is enrolled in a two-year course at Cuyahoga Community Hospital. The scholarship is financed by a pharmaceutical firm. Other pharmaceutical companies have made contributions toward the certification program in 1969 and the overall educational programs of the AAMA.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1969 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, Ohio, May 12-16

1. Title of Exhibit:_____

2. Name(s) of Exhibitor(s):_____

_____

Institution (if desired):_____

City_____

3. Do you have a built-in exhibit?_____

4. Description of Exhibit: (Attach 200 word description to this blank)

5. Exhibit will consist of the following: (Check which)

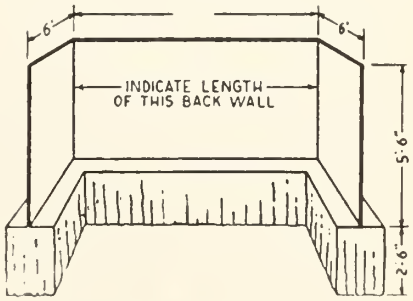
Charts and posters_____ Photographs_____ Drawings_____ X-rays_____

Specimens_____ Moulages_____ Other material_____
(Describe)

6. Booth Requirements: (See Sketch)

Back wall_____ All sidewalls are 6′ deep
(Indicate Footage)

Shelving: Shelves are 12 inches deep at a height of 2 feet 6 inches from the floor. Please indicate if you require shelves (yes or no)_____.



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

7. Transparency Cases:

Needed? (yes or no)_____
If answer "yes," give following information:
Number of transparencies to be shown and size of each

_____

_____

_____

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date_____

_____
Signature of Applicant

_____
Mailing Address, Street

_____
City, State, Zip Code

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC WORK, OHIO STATE MEDICAL ASSOCIATION, 17 SOUTH HIGH STREET, SUITE 500, COLUMBUS, OHIO 43215

Deadline For Filing Applications, January 30, 1969

OMPAC Did It Again!

Outstanding Record Chalked Up in 1968 Elections; Think Now of Medicine's Stake in Future Contests!

THE 1968 ELECTION is history, and part of that history was written by the Ohio Medical Political Action Committee which chalked up an excellent record on the number of candidates successfully backed for public office. The part played by OMPAC is a reminder of a similar record scored in the 1966 General Elections.

The following summary tells the story:

- OMPAC actively supported candidates in races for 83 offices.
- OMPAC made financial contributions totalling $106,327 to the support committees of candidates.
- A considerable number of other candidates who did not need financial help from the fund, did receive active support from hundreds of physicians, members of their families, and friends in respective districts.
- Of the total amount contributed by OMPAC to candidate support committees, **$90,177** was contributed to committees **supporting candidates for Federal offices.**
- Contributions **totalling $16,150** went to committees representing candidates for seats in the **Ohio General Assembly.**
- For the first time, OMPAC made contributions to committees working on behalf of a candidate for the **Presidency of the United States. He was elected.**
- Financial contributions were made by OMPAC to the campaign committee of the **successful** candidate for a seat **in the United States Senate.**
- OMPAC made financial contributions to the support committees of **16 candidates for seats in the U. S. House of Representatives.** Of the 16 candidates supported by OMPAC, **13 were elected.**
- Candidates for **12 seats in the Ohio State Senate** were aided by OMPAC. Of the 12 assisted financially by OMPAC, **10 were winners.**
- Among the candidates for seats in the **Ohio House of Representatives,** 53 received contributions from OMPAC. **Of the 53 assisted, 47 were elected.**
- **Of the total number of candidates receiving contributions from OMPAC for campaign activities (83), 72 were elected; 11 defeated.**

OMPAC was able to help more candidates in 1968 than in 1966 because it had the pooled membership dues of both 1967 and 1968.

During the 1968 election campaigns, many local **Woman's Auxiliaries** sponsored registration and get-out-the-vote campaigns. **Many wives of physicians did fine volunteer work** at the campaign headquarters of candidates being supported by the medical profession. Some Auxiliary members made contributions to OMPAC for which they received membership cards.

In 1968, more physicians, it is believed, than ever before made **personal financial contributions** to campaigns of various candidates. This may be one reason why OMPAC membership in 1968 was not much higher. These funds, no doubt, were put to good use and helped to make the 1968 elections a victory for many proponents of good and better government at all levels.

* * *

Results Speak Loud and Clear Urge 1969 OMPAC Support

The Ohio Medical Political Action Committee's success in the 1968 General Election speaks for itself and should provide the incentive for even greater support in 1969 and 1970.

Dr. Frank H. Mayfield, Cincinnati, chairman of the OMPAC Board, reminded physicians that OMPAC is indeed the "Strong Right Arm" of Ohio Medicine, and urged doctors to make their 1969 contributions of $25. OMPAC contributions may be made to the County Medical Society treasurer at the same time that the doctor pays his county, state, and national medical organization dues.

OMPAC cannot afford to rest on its laurels, Dr. Mayfield emphasized. Political activity must be a round-the-clock endeavor. It is time for OMPAC to start storing up for the next big political battles scheduled in 1970.

The County Medical Society combined billing procedure, providing for the billing of $25 OMPAC dues on the county society's regular statement for medical society dues is the most effective method

devised for the convenience of physician members and for the good of OMPAC.

Many of the County Medical Societies have adopted this method of promoting OMPAC and will continue to use it for 1969 membership.

Only one disconcerting note entered into OMPAC 1968 experiences, Dr. Mayfield pointed out. Only 2900 Ohio physicians contributed to its cause, whereas the potential membership of doctors alone is double or even triple that number. Now that OMPAC has proven beyond the shadow of a doubt its potent power in the political area, membership for 1969 and 1970 should be much larger.

By taking an active interest in OMPAC and contributing dollars to its support, the individual physician will be playing a leading role in civic responsibility. He will be helping to elect to public office persons deemed by the medical profession to have ability, courage, integrity, and sound views on social and economic questions confronting Ohio and the Nation. He will be helping to put into places of responsibility men and women capable of serving Ohioans efficiently and honestly in various governmental offices.

The cost — $25 — is small compared to accrued dividends in the form of qualified elected officers. A strong bank account bolstered by 1969 and 1970 contributions will enable OMPAC to do another top-notch job in the 1970 campaigns. It should be noted that OMPAC was able to do an excellent job in 1968 because it had combined contributions for 1967 and 1968.

Dr. Mayfield urged physicians to pool their dollars with those of their colleagues in Ohio through the Ohio Medical Political Action Committee. Only by that means can OMPAC continue as the "Strong Right Arm" of the medical profession in Ohio.

Ohio Workmen's Compensation Medical Director Is Named

Oscar L. Coddington, M. D., has rejoined the Bureau of Workmen's Compensation, State of Ohio, as director of the Medical Section. The appointment, effective November 4, was announced by Jay C. Flowers, administrator of the Bureau.



Dr. Coddington

Dr. Coddington was born in Morrow, Ohio, and received his degrees from Ohio State University. He was a general practitioner in Columbus from 1926 to 1958. For five years, from 1957 to 1962 he was medical examiner for the Bureau of Workmen's Compensation. From the latter date to his recent appointment he was associated with the Bureau of Vocational Rehabilitation as medical administrative consultant.

He is a member of the Columbus Academy of Medicine, the Ohio State Medical Association, the American Medical Association, the Ohio and American Academies of General Practice, and the National Rehabilitation Association. He has served on the staffs of several Columbus hospitals and on the faculty of the OSU College of Medicine, Department of Physical Medicine and Rehabilitation.

Dr. Coddington succeeds Raymond B. Hudson, M. D., who retired earlier this year after many years of service with the Bureau.

THE ESTATE BUILDERS

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Group Ordinary Life Insurance

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TWELFTH FLOOR 17 SOUTH HIGH STREET
COLUMBUS, OHIO 43215 PHONE (614) 228-6115

Obituaries

Ad Astra

Charles Sumner Ashfield, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1900; aged 93; died October 17; former member of the Ohio State Medical Association. A physician for many years in Hamilton County, Dr. Ashfield's practice centered in the Mt. Auburn and Norwood areas. He was Norwood city physician also for many years. Cousins survive.

Elizabeth Brill Smith Byron, M. D., Junction City; University of Cincinnati College of Medicine, 1936; aged 57; died April 28; former member of the Ohio State Medical Association. Not in practice recently, Dr. Byron was formerly on the professional staff of the Cambridge State Hospital, and before that was associated with the Veterans Administration Hospital at Chillicothe.

Ernest Bearden Cunningham, M. D., Middletown and Chautauqua; Tulane University School of Medicine, 1944; aged 50; died October 19; recent member of the Ohio State Medical Association and the American Medical Association; member of the Industrial Medical Association. Dr. Cunningham was physician for the Middletown Works of the Armco Company for 12 years. He formerly practiced in the Bristol, Tenn., area, and was a Navy medical officer during World War II. Among survivors are his widow, a son, a daughter, his mother, and a sister.

Donald Emory Dial, M. D., Lakewood; Yale University School of Medicine, 1928; aged 65; died October 1; member of the Ohio State Medical Association, the American Medical Association, American Academy of Orthopaedic Surgeons, Fellow of the American College of Surgeons; diplomate of the American Board of Orthopaedic Surgery. A practitioner in Lakewood for some 30 years, Dr. Dial specialized in orthopaedic surgery and was assistant professor of clinical orthopaedic surgery at the Case Western Reserve University School of Medicine. He served with the American Hospital unit in Britain during the early part of World War II and later with the U. S. Army Medical Corps. Two sons survive. His wife died in 1967.

Arthur M. Harrison, M. D., Napoleon; Yale University School of Medicine, 1939; aged 60; died September 29; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A practitioner for many years in Toledo, Dr. Harrison moved to Napoleon in 1960 after suffering disabling injuries in a traffic accident. Among affiliations, he was a member of the Episcopal Church. Dr. Harrison was born in Bowling Green where his father was a practicing physician many years ago. A sister survives.

Jesse Grant Hilleary, M. D., Santa Barbara, Calif.; Medical College of Ohio, Cincinnati, 1897; aged 94; died June 30. Records indicate that Dr. Hilleary resided in California for many years.

Russell Arthur Jewett, M. D., Beverly Hills, Calif.; Western Reserve University School of Medicine, 1907; aged 84; died June 1; former member of the Ohio State Medical Association, last membership in 1913. Records indicate that Dr. Jewett practiced in the Cleveland area until the 1920's when he moved to California.

Theodore Charles Kiess, M. D., Mountain View, Calif.; Ohio State University College of Medicine, 1924; aged 71; died October 7; member of the Ohio State Medical Association, the American Medical Association, and the American College of Obstetricians and Gynecologists. Dr. Kiess moved to California in 1966 after many years of practice in Toledo. His professional interests extended to several organizations including the Cancer Society and the Red Cross. A member of the Lutheran Church, he is survived by his widow, two daughters, and two sisters.

James Oliver Mattax, M. D., Warren; University of Western Ontario (Canada) Faculty of Medicine, 1934; aged 64; died October 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Mattax practiced in Warren early in his career and was living there in retirement recently. Much of his practice was in Carrollton, Ky., and during World War II he served with the Army Medical Corps. His widow, a son, and a sister survive.

Charles Levi Maxwell, M. D., Belleville, Illinois; Ohio State University College of Medicine, 1916; aged 75; died on or about October 16. A career Army medical officer, Colonel Maxwell was living in retirement. Survivors include his widow, two daughters, a son, a sister, and a brother.

James Robert McAuley, M. D., Perrysburg; Queen's University Faculty of Medicine, Canada,

1926; aged 65; died October 16; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. McAuley devoted some 40 years to practice in the Perrysburg and Toledo area. Among community activities, he was president of a senior citizens housing project in Perrysburg, and as an amateur artist was on the board of Art Interests, Inc. A veteran of World War II, he was a member of the American Legion. Other affiliations included membership in the Catholic Church and the Catholic Physicians' Guild. Survivors include his widow, and three daughters.

Howard C. McMillin, M. D., formerly of Aliquippa, Pa.; Chicago College of Medicine and Surgery, 1907; aged 91; died September 30. Dr. McMillin was residing in Wooster recently after a long practice and period of retirement in Pennsylvania. Dr. Howard C. MacMillan, of Wooster, and Dr. Bruce B. MacMillan, of Pittsburgh, are sons. Other survivors are his widow and two daughters.

Albert Ralph Miller, M. D., East Cleveland; Western Reserve University School of Medicine, 1926; aged 70; died October 20; member of the Ohio State Medical Association, the American Medical Association, the American Academy of General Practice, and the American Geriatrics Society. Dr. Miller practiced medicine for some 40 years in the East Cleveland area. He was a member of the board of trustees of Euclid General Hospital and was active in several Masonic bodies. Survivors are his widow, a daughter, and a son.

Francis Herbert Obetz, M. D., Columbus; Starling Medical College of Columbus, 1900; aged 91; died November 4; former member of the Ohio State Medical Association. Dr. Obetz practiced in Columbus many years ago and retired in 1942 after 35 years of service as Columbus Police and Fire Department physician and surgeon. His widow survives.

John Egnew Schrider, M. D., Toledo; Ohio State University College of Medicine, 1924; aged 69; died October 27; recent member of the Ohio State Medical Association and the American Medical Association. Dr. Schrider devoted some 42 years to practice in the Toledo area, where he specialized in anesthesiology. For 27 years he was Toledo plant physician for the DuPont Company. A member of the Gesu Church, he is survived by his widow, a son, a daughter, and a sister.

Alfred Gordon Schulze, M. D., Amelia; University of Cincinnati College of Medicine, 1939; aged 55; died October 27; member of the Ohio State Medical Association and the American Medical Association. A practitioner of many years standing in the Clermont County area, Dr. Schulze was on the staffs of Cincinnati Hospitals. He was a veteran of World War II, during which he served in the Medical Corps. His widow, a daughter, and a son survive.

Allan Lee Wasserman, M. D., Dayton; University of Cincinnati College of Medicine, 1949; aged 44; died October 8 while vacationing in Japan; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A native of Cincinnati, Dr. Wasserman practiced there for some 17 years. In 1966 he was awarded the Jewish Community Council President's Leadership award for community project leadership. He was active on several national appeal organizations, was medical division chairman for the local United Appeal, was chairman of his local synagogue action committee, and active in other community affairs. He was a veteran of World War II, during which he served in the Army Medical Corps. Among survivors are his widow, a daughter, a son, his mother, a sister, and a brother.

William Kerr Zollinger, M. D., Toledo; University of Cincinnati College of Medicine, 1939; aged 54; died October 17 while on a vacation trip in Virginia; member of the Ohio State Medical Association, the American Medical Association and American Academy of Pediatrics; diplomate of the American Board of Pediatrics. Dr. Zollinger practiced for 22 years in Toledo, specializing in pediatrics. He was a veteran of World War II during which he served in the Air Force Medical Corps, was a member of the Rotary Club, the Presbyterian Church, the Inverness Club, and other groups. Survivors are his widow, three sons, and two brothers.

Activities of County Societies...

ATHENS

The Athens County Medical Society met for luncheon and a program at the nurses' dining room of Sheltering Arms Hospital early in October.

Highlight of the meeting was presentation of the Ohio State Medical Association's Fifty-Year award to Dr. Blaine R. Goldsberry, practicing physician in the Athens area since 1921 and a Navy medical officer during World War I. Dr. Goldsberry is a past president of the Society, former president of the city-county board of health, and active in numerous community affairs.

Presentation of the award was Dr. William W. Wells, Newark, Councilor of the Eighth OSMA District.

BELMONT

The Belmont County Medical Society met at the Belmont Hills Country Club on October 17 for an afternoon program and dinner. Members of the Auxiliary were invited guests which included members of the local county board of mental health.

Program speaker was Dr. Wendell A. Butcher, Columbus, chairman of the OSMA Committee on Mental Health, whose topic was "Recognition of Depression in Adults and Children." Another feature of the program was showing the film, "The Mask of Depression."

CUYAHOGA

A program on Medicine and Religion was conducted by the Academy of Medicine of Cleveland on October 30 with a discussion on the theme, "Guilt as Related to Illness."

Moderator was Dr. J. Kenneth Potter, director of the Department of Anesthesiology, Huron Road Hospital. The following speakers completed the panel:

The Reverend Doctor Granger E. Westberg, professor of practical theology and director of continuing education, Hamma School of Theology, Wittenberg University, Springfield.

Chaplain Ralph R. Boyer, Fairview General Hospital, Cleveland, and member of Committees on Medicine and Religion for the AMA and for the local Academy.

Dr. Leonard L. Lovshin, head of the Department of Internal Medicine of the Cleveland Clinic.

FRANKLIN

The Honorable M. E. Sensenbrenner, Mayor of the City of Columbus, was speaker for the October 15 meeting of the Academy of Medicine of Columbus and Franklin County. The meeting at the Imperial House North in Columbus followed a social hour and dinner.

Mayor Sensenbrenner's topic was "The Road Ahead," a discussion of the citizen's responsibility in the development and growth of the community.

LORAIN

A Social Hour and Dinner at Oberlin Inn on October 8, preceded the business meeting of Lorain County Medical Society.

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President Delbert L. Fischer welcomed guests from Medical Mutual of Cleveland — Christopher Colombi, M. D., medical director; Messrs. Edward C. Lechner, president; Carl D. Bonfils, vice-president; and Robert Graber, Medicare director. They outlined the proposed Usual, Customary and Reasonable Fee Plan, and opportunity was afforded for a detailed discussion and question period.

During the business meeting, the following physicians were elected unanimously to Associate membership in the Medical Society: Drs. D. M. Abella (Lorain); Jorge T. Froilan (Oberlin); William Nichols (Elyria) and Ronald A. Schwert (Vermilion).

Members elected to Active status following a year as Associates were: Drs. Richard Buchanan (Elyria) and Maximo Oania (Elyria).

An application for membership from G. T. Derikito (Wellington) received a first reading.

Dr. Fischer reported on the District Conference in September, stressing the importance of supporting and voting for qualified candidates for public office at the November elections.

MAHONING

J. Stanley Johnstone, executive director of the Mahoning Valley Health Planning Association, was featured speaker for the October 15 meeting of the Mahoning County Medical Society. The meeting in the Mural Room was preceded by a social hour and buffet dinner. Mr. Johnstone discussed health planning in the vicinity.

Dr. Mark T. Hoekenga has been promoted to the newly created position of director of medical affairs in the research organization of the Wm. S. Merrell Company, pharmaceutical division of Richardson-Merrell Inc. He joined Merrell in 1961. Dr. Hoekenga also holds medical faculty appointments at the University of Cincinnati College of Medicine, and at the University of Kentucky, and is visiting professor of tropical medicine at the University of Miami.

Dr. John C. Starr, charter member of the London Kiwanis Club, was named at the recent Ohio Kiwanis Convention in Cincinnati as lieutenant governor of Kiwanis Division 10-W which is composed of ten clubs including the London group.

A feature article in the *Columbus Dispatch* announced the retirement of Dr. Charles C. Deamude, a physician in the Washington County community of Beverly for 35 years. His immediate plans are to catch up on travels abroad, the article reported.

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Woman's Auxiliary Highlights . . .

By MRS. ROBERT E. PUMPHREY, Chairman, Publicity Committee

3055 Big Hill Road, Dayton 45419

Congratulations and Best Wishes to Mr. Richard M. Nixon, President-Elect of the United States of America . . . Preelection County Events . . . Health Career Days . . . Community Health Service . . . Adele Simpson Designs Score Hit at Scholarship Awards.

CONGRATULATIONS AND BEST WISHES to Mr. Richard M. Nixon, president-elect of the United States of America. Holiday Greetings to all readers of this column. It hardly seems possible that Christmas is "just around the corner" and the New Year is on the horizon — a year that we all sincerely hope will bring peace and unity at home and abroad.

Your Wives Make It Possible

October and November were certainly event packed months. This columnist would like to express gratitude to your wives, doctors — to WA-OSMA presidents, presidents-elect; chairmen and others who have so generously sent in detailed news of county activities. As you read of these exciting happenings, you will know they could not have been compiled without cooperation. We are anxious to have the total report on how we did on the sale of Christmas cards; golf balls; and the DOCTOR'S WIFE ROSE bushes, for the benefit of AMA-ERF. This year's Christmas card selection was the loveliest ever.

"Republicrat" Ox Roast

News has come in of a "Come, Whether Republican or Democrat" rally and fall meeting of the Woman's Auxiliary of the Muskingum County Medical Society for the entertainment of husbands. The combined meetings are annual affairs. This year the meeting was held at the home of Dr. and Mrs. A. E. McGinnis. Cohost and hostess were Dr. and Mrs. Peter Fomenko. Auxiliary President, Mrs. Walter Devine says everyone had a marvelous time.

Entertainment "candidates" delighted their audience —a fun "MEET THE PRESS" interview was held— (actually, Minnie Predmore of the *Times Recorder* in Zanesville, gave a glowing account of the rally)— "CORN MUSIC" was staged by Dr. Charles Cerney and Dr. Earl Haynes.

Beef was roasted in a huge pit while torches glowed in the dark. Activities were physical as well as mental, including volleyball and horseshoe pitching. Wouldn't it have been fun to have been there?

1968 Nurse's Scholarship Award Given at Pan American Collection Showing and Benefit

Woman's Auxiliary to the Montgomery County Medical Society and guests were thrilled with the beautiful trunk showing of a famous designer, Adele Simpson, at a benefit luncheon held at Dayton Country Club in October. This was a prelude to a

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Principals in the Montgomery County Nurses' Scholarship Award for 1969 are shown, from left: Mrs. Clifford Gebhart, scholarship chairman; Mrs. Neal Perkins, president, Montgomery County Auxiliary; Miss Karen Naas, scholarship winner; Mrs. Byron Lee and Mrs. William A. Roll, social committee cochairmen.

(See details in the Auxiliary Highlights column.)

yearly event that is being sponsored by Rike's of Dayton, for the benefit of the Nurse's Scholarship.

Chairmen for the event were Mrs. Jack Weiland and Mrs. Donald A. Buck. Excellent news coverage was by the *Dayton Daily News;* the *Journal Herald:* and the *Kettering Oakwood Times.* Each yearly fashion show will feature a different famous designer.

Recipient of this year's nurse's scholarship, Miss Karen Marie Naas, is an attractive 18 year old brunette with a sparkle in her eyes. She is a graduate of Patterson Co-Op and has worked at Good Samaritan Hospital in Dayton for two years as a nurse's aide and will enter St. Elizabeth Hospital this fall. She earned $1600 during her high school days and has saved $500 toward her career. She has been a Girl Scout, a member of Future Nurses Club and Girl's Volleyball Team.

Interlude

The Adele Simpson Collection was represented by ultra chic Sandra Barrett.

Gentlemen, Miss Barrett says that Mrs. Simpson believes that American women have beautiful legs so why shouldn't they show them? She also said that short skirts are still very much in style and if your lady wears them an inch shorter than she thinks they should be, she'll be happier and in vogue.

Miss Barrett describes velvet—that gorgeous clingy fabric—as being a "language without words." Maybe you'd like to put a little of that language into milady's Christmas if you haven't already decided on something—a dress jacket, evening coat, negligee, purse . . .

Bittersweet Ball Benefits, AMA-ERF

According to Mrs. D. M. Creamer, publicity chairman of the Woman's Auxiliary to Belmont County Medical Society, the annual Bittersweet Ball, a fund raising project for AMA-ERF, was changed from a dinner dance to a tea dance and was far more sweet than bitter—in fact, was a real success. In addition to AMA-ERF these local and regional projects also benefited this year: Project Hope; Volunteer Service Counsel Cambridge State Hospital; Belmont County Mental Health Program and the school for retarded children.

"The Many Faces of Depression" was the topic of a talk by Dr. Wendell Butcher, chairman of Committee on Mental Health of the Ohio State Medical Association, presented in October at a joint meeting of the Belmont County Auxiliary and Medical Society. In November the Auxiliary brought unwrapped Christmas gifts for Cambridge State Hospital to their meeting. Mrs. Creamer says the membership committee of the Auxiliary is stressing new members. We are so happy to hear it!

Health Careers Day was sponsored in November by the Montgomery County Medical Auxiliary and was held at Patterson Co-Op High School. Chairmen were Mrs. Michael O. Phillips; Mrs. Jacques O'Hara and Mrs. Owen McFall.

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The Seminar was designed to make counseling on medical and associated careers available to students, parents, and guidance counselors.

Conferences, with qualified leadership, included counsel in the following fields: dental hygiene; dentistry, dietetics; earn-while-you-learn; inhalation therapy; medicine; medical assistant; medical social work; occupational therapy; pharmacy; practical nursing; professional nursing; veterinary medicine; and x-ray technology.

Sex Education Panel

A panel on Sex Education was held in November by Richland County Medical Auxiliary—Dental, Bar, Veterinarian, and Pharmaceutical Auxiliaries were invited. Mrs. Raymond N. Stephens was program chairman. Members of the panel were a physician, a school superintendent, a minister, and a psychologist. The auxiliary hoped by this means to promote and develop a program in the public schools—another plan to carry out the 1968 Auxiliary theme, ACCENT ON YOUTH.

Musical in a Capsule

A luncheon meeting of the Woman's Auxiliary to Lima and Allen County Academy of Medicine featured a vocal program that capsuled a hit Broadway musical. Mrs. Dwight Becker is president of the Auxiliary. Hostesses were Mrs. W. E. Shankland, chairman; Mrs. James Belt; Mrs. H. C. Kingsbery; Mrs. A. Frank Portmann; Mrs. Thomas Rockwell; Mrs. Todd Stallkamp and Mrs. C. D. Steinecker.

Holiday Decorating Luncheon

This December Lorain County Auxiliary will hold a joint meeting with husbands, and an auction, according to Mrs. John Bartone, president. In November a Holiday Decorating Luncheon was held with a speaker from Botamer Florists.

Letter from Legislative Chairman:

"Hi—just wanted to tell you that I read your publicity in the October Journal and I thought it was really excellent—I like your style very much. I promise to send you something (news, I'm sure she means) after election and our moving to Florida."

Thank you very much, Frankie. I'm sure we all know you're doing a tremendous job as legislation chairman and member of OMPAC board.

Ohio Physician Heads National Anesthesiology Group

Carl E. Wasmuth, M. D., LL. B., head of the Department of Anesthesiology at Cleveland Clinic Hospital, was installed as 1968-1969 president of the American Society of Anesthesiologists at the organization's annual meeting in Washington, D. C., October 21-23.



Dr. Wasmuth

Dr. Wasmuth's career includes both medicine and law. He is a diplomate of the American Board of Anesthesiology and a Fellow of the American College of Legal Medicine. He is the author of three books on legal medicine and does editorial work in the medical and legal publications field. Before being named president-elect of the American Society of Anesthesiologists last year he was speaker of its house of delegates for several years.

The meeting was marked by a new high in attendance of 3,794. The new president-elect of the organization also has ties in Ohio. Dr. John E. Steinhaus, professor and chairman of the Department of Anesthesiology, Emory University, took his internship training at Cincinnati General Hospital. He will succeed Dr. Wasmuth as president at next year's annual meeting of the society.

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FULL-TIME EMERGENCY ROOM PHYSICIANS — Immediate need for two physicians to practice with a highly successful incorporated emergency group at 600-bed Toledo Hospital. Salary presently $21,000 per year for 40-hour week with tax free extras and two weeks paid yearly vacation. Must be eligible for Ohio State license. Energetic trauma and acute-illness oriented men preferred. Ideal situation for recent residency graduate or those completing military service who need immediate good income. Contact: Donald K. Harrison, M. D., 2425 Detroit Avenue, Maumee, Ohio. Phone 419-893-8746.

OPPORTUNITY FOR A GENERAL PRACTITIONER OR INTERNIST. I am now past 75 and desire to retire. Practiced in the West End area in Cincinnati for forty years. Complete office with x-ray, physiotherapy, etc. In order to realize such an opportunity, write Box 564, c/o Ohio State Medical Journal.

STUDENT HEALTH PHYSICIANS — 1 immediate opening, Northeast Ohio, 13,000 students, modern new facility, complete inpatient and out-patient services, excellent salary, fringe benefits, vacation, and working conditions. Reply Box 566, c/o Ohio State Medical Journal.

PHYSICIAN TO SUPERVISE BLOOD COLLECTION in the Columbus Red Cross Blood Center and the bloodmobile. Interested in one full time or two half time physicians. Contact: Sergio L. Cruz, M. D., Director, Central Ohio Blood Center, 995 East Broad Street, Columbus, Ohio 43205. Telephone: 253-7981.

SPACIOUS NEW MEDICAL BUILDING — Colonial styling — suburban — latest facilities — plenty parking — ready in November — productive practice waiting — Orchard Springs Medical Building, 5925 N. Main Street, Dayton, Ohio 45415.

RETIREMENT MAKES AVAILABLE EXCELLENT EENT PRACTICE in desirable northern Ohio lake region. Rapid industrial and residential expansion making great demands on available medical services. Office space and hospital facilities of highest grade. Equipment for sale in part or entire at appraisal value. Reply Box 565, c/o Ohio State Medical Journal.

HOUSE STAFF PHYSICIAN: Active 269 bed JCAH approved general hospital. Foreign graduates acceptable with ECFMG certificate. Salary negotiable. Write to Administrator, St. Joseph Hospital, 205 West 20th St., Lorain, Ohio 44052.

WANTED: EYE, EAR, NOSE, & THROAT PHYSICIAN to take over practice of recently deceased physician in Wheeling, West Virginia. Office completely equipped and ready for immediate occupancy. Contact. Mr. Jos. M. Follen, Extr., 40—12th Street, Wheeling, W. Va. 26003.

OFFICE SPACE AVAILABLE: Medical-Dental Center Building. Formerly occupied by retired pediatrician. Other offices in building include gynecologist, surgeon, internist, and two dentists. Lack of physicians in area guarantees maximum income. Write to 2017 Sunset Blvd., Steubenville, Ohio 43952, or call Area Code 614-282-5351. Dr. S. Fisher.

RADIOLOGIST, INDIANA VA—Salary $20,000 to $23,000. Liberal fringe benefits. Write or call Chief of Staff, Veterans Hospital, 1600 Randalia Drive, Fort Wayne, Indiana 46805. An Equal Opportunity employer.

PHYSICIAN TO RUN EMERGENCY ROOM in Southeast Ohio Hospital; doctor needed who can adjust to local situation, including out-patient care; salary $25,000; terms and details may be discussed with Harold J. Rolph, Administrator, Lawrence County General Hospital, Ironton, Ohio; Phone (614) 532-3231.

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

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Each yellow tablet contains:

Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
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Dose: 1 tablet 3 times daily.
Available:
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Dose: 1 tablet 3 times daily.
Available:
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Android-X

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Each orange tablet contains:

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WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

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Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.

***Dose:* 2 tablets daily.**
***Available:* Bottles of 60, 500.**

Write for literature and samples:

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2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO PDR

also available with ESTROGEN

Android —E

Each Tablet Contains:

Methyl Testosterone . . . . . 2.5 mg.
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Glutamic Acid . . . . . 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

In treatment of
cold feet
leg cramps
tinnitus
discomfort on standing

LIPO-NICIN®/100mg.
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A peripheral vasodilator/safe and potent



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Each blue tablet contains:

Nicotinic Acid . 100 mg.
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Dose: 1 to 5 tablets daily.
Available:
Bottles of 100, 500, 1,000.

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Each yellow tablet contains:

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Niacinamide . . 75 mg.
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Thiamine HCl (B-1) . . . . 25 mg.
Riboflavin (B-2) . 2 mg.
Pyridoxine HCl (B-6) . . . . 10 mg.

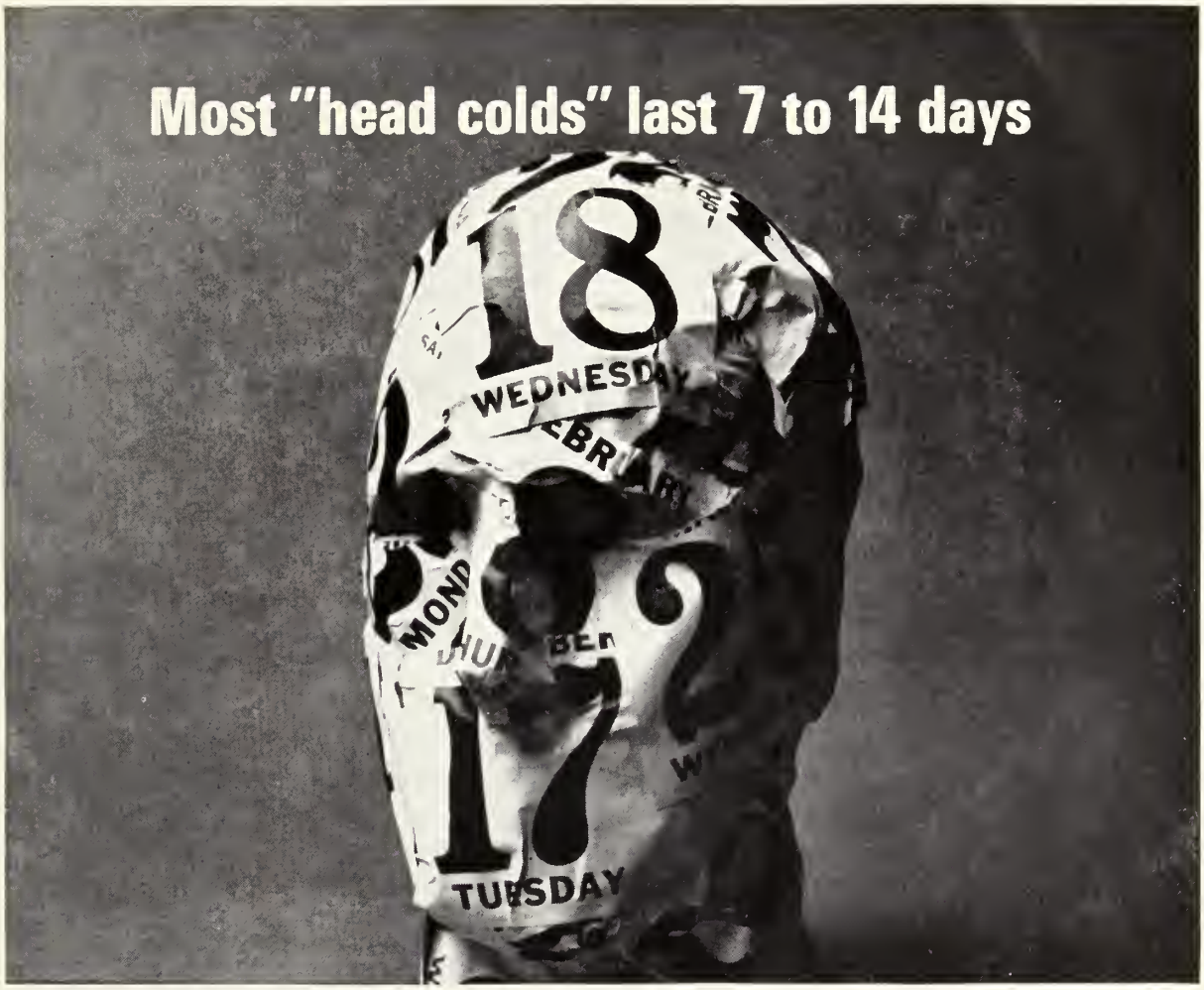
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INDICATIONS: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins.

The warm tingling flush which may follow each dose is one of the therapeutic effects that often produce psychologic benefits to the patient.

SIDE EFFECTS Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid.

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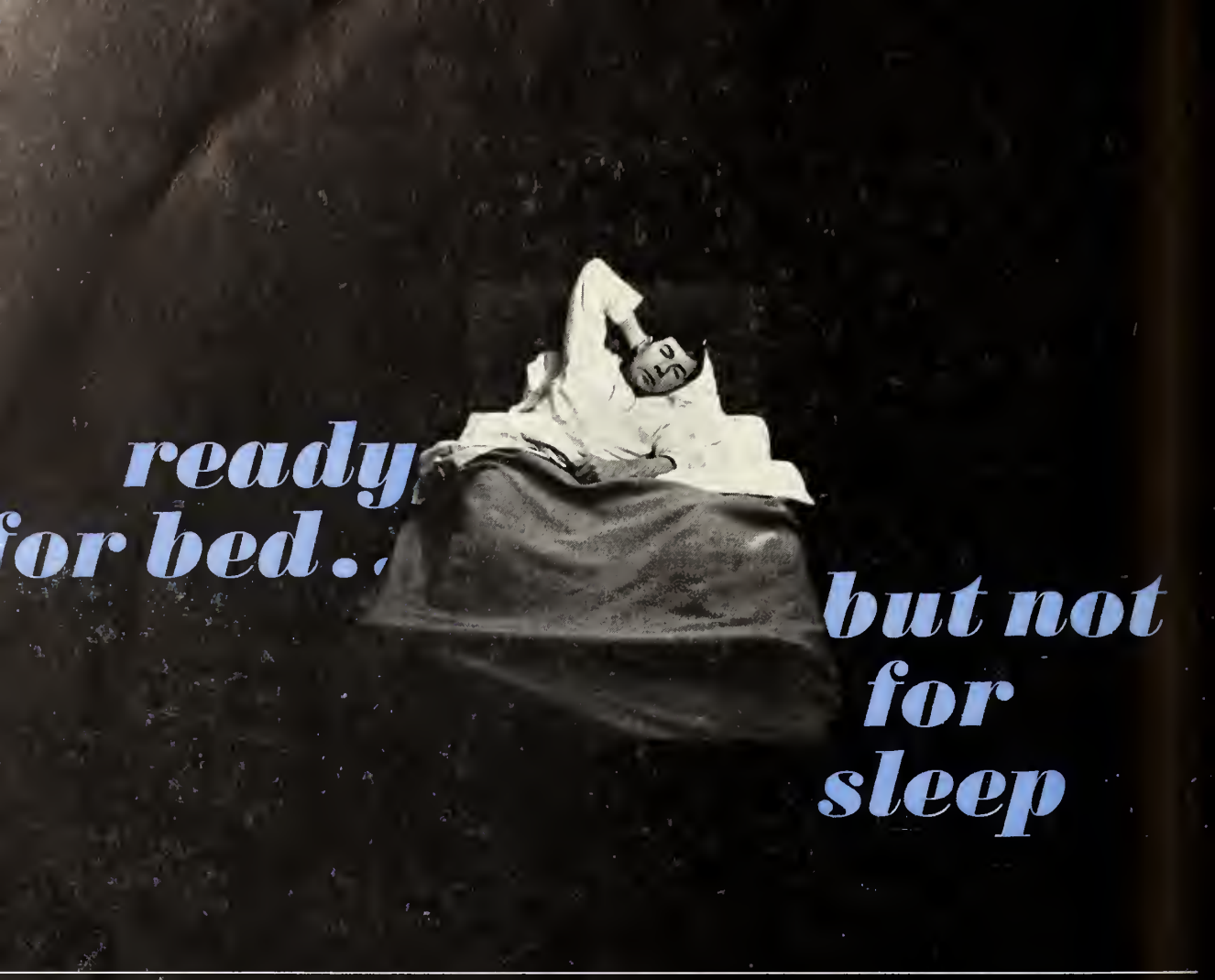
Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease, warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark. Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, 2.5 mg. of isopropamide, as the iodide.
Spansule® capsules brand of sustained release capsules

SK&F Smith Kline & French Laboratories



ecause psychic tension ay not stop at night

e calming action of Valium (diaz-
am) helps counteract psychic ten-
n and reduce overreaction to
esses during the day. Often the t.i.d.
sage schedule is enough to prevent
ild-up of tenseness that may inter-
e with sleep at night.

wever, when psychic tension does
ntribute to sleeplessness, Valium
n be especially useful. A tablet at
dtime, added to the daytime t.i.d.
sage, can help your patient be
dy for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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(diazepam)

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